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SENATE

REPORT
99-306

ALTERNATIVES TO HOSPITALIZATION FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN ACT OF 1986

MAY 21 (legislative day MAY 19), 1986.—Ordered to be printed

Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 1793]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1793) to amend the Public Health Service Act to establish a grant program to develop improved systems of caring for medical technology dependent children in the home, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

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I. SUMMARY OF THE BILL

As reported by the Committee on Labor and Human Resources, S. 1793 would direct the Secretary of Health and Human Services to establish a new grant program under the Public Health Service Act to develop improved systems of home care for medical technology dependent children. Grants would be made to establish and maintain systems which provide alternatives to hospitalization for medical technology dependent children through home and community-based services. Grants would also be made to provide training for individuals who care for medical technology dependent children and for technical assistance to agencies, institutions, and organizations providing care to medical technology dependent children. In making grants to establish systems, preference would be given to state agencies which administer programs under Title V of the Social Security Act; in making grants for training and technical assistance, preference would be given to children's hospitals and academic medical centers. The bill sets a premanent authorization of $20 million for each fiscal year beginning with FY 1986.

The second part of this bill would require the Director of the Congressional Office of Technology Assessment to appoint a taskforce to develop a model provision for coverage of home health care for medical technology dependent children under employee health benefit plans. This model provision would specify what services must be covered. The provision would not require expenditures for home care greater than those that would be made if the child were treated in a hospital. Similarly, no limit would be placed on total payments for home care lower than the limit placed on inpatient hospital services for the same condition. Within 18 months of the appointment of the taskforce, a final report would be submitted to the Director of the Congressional Office of Technology Assessment and the Secretary of Health and Human Services.

After 30 months, the Secretary, in consultation with state insurance commissioners, would determine if less than 80 percent of the employee health benefit plans include coverage which is equivalent to the model provision. If the Secretary determines that less than 80 percent of the plans have voluntarily included provisions, then the Secretary could issue regulations requiring mandatory inclusion of such a provision.

Under the mandated coverage, the employee benefit plan would cover home care in lieu of inpatient hospital care for all medically dependent children who are covered under the employee health benefit plan for inpatient services. In order to be eligible, children covered under the provision would have to need inpatient hospital services for one month or longer if not for the availability of this home care. Only children for whom home care has been determined medically appropriate by a physician would be eligible for this coverage. In order to qualify, necessary services would have to be available, and the individual's family would have to desire to provide or assure the provision of these services. Limits on coverage of home care for technology dependent children could not differ from similar limits on coverage of inpatient hospital services.

Under this legislation, the term "home care for medical technology dependent children" means services required for extended intensive home care of children dependent on medical technology in lieu of inpatient hospital services. These services would be determined by the Secretary and could include services of a type not otherwise covered under the employee benefit plan. The "medical technology dependent child" under this legislation is defined as an individual, under age 21, who has a medical condition which would require inpatient hospital services in the absence of home or community-based care. This individual must be dependent upon medical technology in order to avoid death or serious injury.

This legislation defines "employee health benefit plan" as any plan of an employer that provides or contributes to a plan to provide medical care for its employees, former employees, or the families of such employees, or former employees, directly or through insurance, reimbursement or otherwise. "Employers" included under this law include any nongovernmental employer required to pay its employees minimum wage under the Fair Labor Standards Act of 1938, state or local governments which employed an average of 25 or more employees, and the government of the United States or any agency or instrumentality of it. Excluded from the term "employer" are churches, conventions, or associations of churches, or organizations operated, supervised, or controlled by churches, their conventions or associations of churches which are described in sec. 5019c)(3) of the Internal Revenue Code of 1954.

Penalties for state and local governments which violate the requirements established under the mandatory coverage provision, would be the same as those authorized in section 1310(g) of the Public Health Service Act for state and local governments providing Health Maintenance Organizations as an option under their employee health benefit plans. These include the termination of payment to the state of funds under several Public Health Service Act Authorities. Penalties for private employers will be the same as those authorized in section 1310(e) of the Public Health Service Act. The penalty would be a civil penalty of no more than $10,000 with an additional civil penalty of up to $10,000 for every 30-day period of continued noncompliance.

Employers would not be required to pay more for health benefits as a result of this Act than they would otherwise be required by any prevailing collective bargaining agreement or contract established prior to the enactment of this change into law.

This legislation would amend Section 8904 of title 5 (Federal Employees Health Benefits) and Section 1077 of title 10 (CHAMPUS program) of the United States Code to ensure that some care for medical technology dependent children would be provided under these programs in accordance with the provisions of new Title 22 of the Public Health Service Act.

The Secretary of Health and Human Services would monitor and evaluate the implementation of the amendments made by this legislation. The evaluation would focus on the number of medical technology dependent children receiving home care in lieu of inpatient hospital services, the cost of home care and hospital care for various categories of medical conditions requiring medical technology, and the health status of the children receiving home care and those receiving inpatient hospital services.

II. HEARINGS

The Committee on Labor and Human Resources held a hearing on the home care of chronically ill children on June 18, 1985. Providers and representatives of organizations of providers; parents and representatives of organizations for parents of chronically ill children; and government officials testified of the problems involved in the care of these children. A number of providers described the benefits of home health care for these children. Parents spoke of the financial as well as physical and psychological strain that is experienced when these children are unable to receive care at home. Most of the parents spoke of the need for health insurance coverage of home health care for children with severe chronic conditions.

Professionals testified that care management is the key to ensuring continuity and comprehensiveness of care, as well as cost-effectiveness. A case manager coordinates all the different kinds of services needed by a technology dependent child and assures that there is no duplication of these services. Case management is currently reimbursable under the Katie Bechett waiver; however, the Committee heard testimony that this should be a standard reimbursable home care service.

The Health Insurance Association of America provided written information that indicates a higher prevalence of insurance coverage than discussed in previous studies and/or hearings.

Results reported from an Association conducted survey in 1980 indicated that 43 percent of all the employees reported had coverage for home health care expenses. This percentage increased to 53 percent from all responses to a 1984 survey.

A survey of 57 percent of the largest commercial writers of group health insurance conducted in 1981 showed that at that time 81 percent of the companies include reimbursement of home health care expenses in group contracts. However, the survey did not indicate the adequacy of home health coverage relative to the services needed by technology dependent children.

III. BACKGROUND AND NEED FOR LEGISLATION

Recent medical advances have been responsible for the survival of many infants and children who would have otherwise died. This progress, however, has resulted in an increase in the number of infants and children who are dependent on advanced medical technology for an extended period of time. Other medical advances have made it possible for technology dependent children, who previously required extended periods of hospitalization, to receive care at home. Home care may make more sense than long-term hospitalization for certain chronically ill children, such as some ventilator dependent children. However, these children are finding it difficult to gain access to suitable home care services because of financial and organizational barriers.

Child development literature suggests that pediatric home care may be better for many children and their families than extended hospital care. For those technology dependent children who can be suitably provided with home care—physical, social, and emotional development improves in a supportive home environment over an institutional environment.[1] Many children seem to thrive when they can participate in family, school, and community life. Parents may also prefer that the child be treated in a home setting. In addition, there is a societal interest in keeping the family intact.

However, home care may not take the place of hospitalization for all children and should be viewed instead as part of a continuum of care. Some believe that the major benefit of home care for certain sick children may be that it allows an earlier release from the hospital. For others, home care may never be appropriate: certain families may not be able to cope with the strain of home care and some children may never become well enough for home care to be suitable.

According to a recently published review of studies focusing on the cost effectiveness of home care, a number suggest that pediatric home health care may also be preferred over hospitalization on the basis of cost.[2] Chronically ill children's share of overall child health spending is disproportionately high; hospital costs account for a large share of the costs of treating chronically ill children.[3] A number of studies have documented situations (e.g., certain ventilator dependent children) where the expense per case for pediatric home care is less than for institutional care, although studies also show such care does not guarantee savings in all cases of chronically ill children.

A major obstacle to providing home health care for technology dependent children is monetary.[4] Parents may find it difficult to finance care for their technology dependent children at home because of the high cost of care. Even parents with income often find it inadequate because of the following gaps in private health insurance coverage.[5]

A. The underinsured

1. *Overall liability limits.*—Private insurance plans set limits, or caps, on the total insurance liability for home care. These limits are often set lower than the limits for hospital care.

2. *Lack of home care coverage.*—Private insurance often excludes home care from coverage. For example, a plan may cover only hospital and physician expenses. Medicaid, in contrast to many private health plans, allows states to provide home care to individuals who would otherwise require institutional care (under Medicaid "2176" waivers").

3. *Limited home care coverage.*—Even when an insurance plan covers medical services necessary for home care, it may not cover other important support services. Chronically ill children may not be covered for physical therapy, occupational therapy, speech and

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[1] Kohrman, Arthur F., M.D., Director, La Rabida Children's Hospital and Research Center, Department of Pediatrics, The University of Chicago. Testimony before U.S. Senate Labor and Human Resources Committee on home health care for chronically ill children and conversation with Dr. Kohrman.

[2] "Cost Effectiveness of Pediatric Home Care," Caring. v. IV, No. 5, May 1985, p. 48.

[3] Shannon, Karen A. National Executive Director, SKIP, Inc. Testimony before the U.S. Senate Labor and Human Resources Committee on home health care for chronically ill children.

[4] Shannon, Karen A., National Executive Director, SKIP, Inc. Testimony before U.S. Senate Labor and Human Resources Committee on home health care for chronically ill children, June 18, 1985.

[5] Conversation with Josephine Gittler, Coordinator, National Maternal and Child Health Resource Center, Apr. 7, 1986.

hearing therapy, nutrition services, prescription drugs, or adaptive equipment (e.g., wheelchairs). In addition, the families of these children may not be covered for counseling, respite care or other necessary services.

There are other obstacles to providing home health care for technology dependent children. Families now seek the services of many providers functioning within multiple private offices, agencies, institutions, foundations, and service organizations. Chronically ill children often require a variety of services from diverse numbers of providers: the primary care physician, specialists, community hospital, tertiary hospital, nurses and other home health personnel, school officials, and providers of other support services may all share responsibility for a battery of medical and social services. Coordination of these multiple care givers is difficult. In addition, not all communities may currently have enough providers trained to care for the growing number of chronically ill children.

IV. COMMITTEE VIEWS

The Committee has determined that there are a number of children, who because of injury or congenital disorder, find themselves dependent on advanced medical technology for an extended period of time. In addition to injury-causing accidents, a variety of diseases or birth defects can lead to such dependency. These conditions include cancer, osteomyelitis, neurological trauma, progressive neurological disease, and cardiac and pulmonary disorders. Such children may require advanced technology therapies such as mechanical ventilators, or long-term intravenous nutrition or drug therapy.

The Committee has learned that many of these technologies—which previously required extended hospitalization—can now be provided at home. Recent technological advances have made this possible; medical equipment is becoming increasingly more portable. Improved methods for delivering health care are also responsible for the success of home care. Creative use of multidisciplinary support items has enabled very sick children to receive care in their homes.

The Committee believes that home care is often better, in human terms, for sick children and their families than long-term or permanent hospitalization. The Committee also believed that home care can often be provided less expensively than hospital care.

However, the Committee is concerned that parents who seek to care for their technology dependent children at home are often not able to do so because of gaps in private insurance coverage.

Health insurers have denied coverage for home care in cases where the same care would be fully covered, at much greater cost, if provided in a hospital or other institution. This situation may result from current deficiencies in some private insurance coverage. For example, the costs of care for chronically ill children may exceed the limits or caps set on total insurance liability for home care. These caps may be set lower than the limits for hospital care in order to prevent long-term coverage for chronic conditions. The Committee believes such policies do not make financial sense when applied to children who require intensive medical services and therefore must be hospitalized in the absence of home care.

Health insurers traditionally have not covered such services as case management, respite care, and technical assistance to family members. The Committee believes these services are essential to successful home care. This concern is the basis for the requirement that the Office of Technology Assessment (OTA) appoint a task force to develop a model insurance provision for medical technology dependent children. However, the Committee is aware that the O.T.A. is currently conducting a study on home care for medical technology dependent children. To the extent possible, this information will be used to fulfill the requirements of the legislation in order to prevent duplication of effort and limit expense.

In addition, to limited insurance coverage, the resources are often not available to ensure that care is provided even if it is financially covered. The success of pediatric home care depends on training of health personnel, development of technically proficient home care organizations, and coordination of a variety of services. The Committee is concerned that these resources do not currently exist in many communities.

As the availability of home care for chronically ill children increase, the importance of monitoring the costs and quality of such care must also increase.

The Committee believes S. 1793 makes significant progress towards addressing the barriers to effective home care for children with severe medical dependencies as a result of insurance coverage and resource availability problems.

V. TEXT OF BILL AS REPORTED

A BILL To amend the Public Health Service Act to establish a grant program to develop improved systems of caring for medical technology dependent children in the home, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Alternatives to Hospitalization for Medical Technology Dependent Children Act of [1985".] *1986".*

PUBLIC HEALTH SERVICE ACT AMENDMENT

SEC. 2. (a) [IN GENERAL.—The] *The* Public Health Service Act is amended by adding at the end thereof the following new title:

TITLE [XXII] *XXIII*—HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN

PART A—GRANTS RELATING TO HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN

“GRANTS RELATING TO HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN

SEC. [2201.] *2301.* (a) [IN GENERAL.—The] *The* Secretary shall make grants for the purposes of—

(1) establishing and maintaining, through collaborative efforts with other interested agencies, institutions, organizations, groups, and individuals, systems for safe and effective home and community-based services which provide alternatives to hospitalization for medical technology dependent children (as defined in section [2243)] *2313);*

(2) providing training for individuals who provide care to medical technology dependent children; and

(3) providing technical assistance to agencies, institutions, and organizations which provide care to medical technology dependent children.

(b) [GRANT RECIPIENTS.—Grants] *Grants* under this section may be made to State agencies administering programs under title V of the Social Security Act which relate to medical technology dependent children, academic medical centers, and children's hosptials. *In making grants under paragraphs (1) and (3) of subsection (a), preference shall be given to State agencies administering programs under title V of the Social Security Act. In making grants under paragraph (2) of subsection (a), preference shall be given to academic medical centers and children's hospitals.*

(c) [APPLICATION.—The] *The* Secretary shall establish procedures for applying for grants under this section.

(d) [AUTHORIZATIONS.—For] *For* purposes of making grants under this section there are authorized to be appropriated $20,000,000 for each fiscal year, beginning with fiscal year 1986.

PART B—REQUIREMENTS FOR EMPLOYEE HEALTH BENEFITS PLANS

DEVELOPMENT OF MODEL COVERAGE PROVISION

SEC. [2210.] *2311.* (a) [DEVELOPMENT OF MODEL.—The] *The* Director of the Congressional Office of Technology Assessment shall appoint a task force for the purpose of developing a model provision for coverage of home care for medical technology dependent children (as defined in section [2213)] *2313)* under employee health benefit plans. The model—

(1) shall not specify services which must be covered for such children;

(2) shall not require expenditures for home care which are greater than those which would be made if care for the same condition were rendered in a hospital setting; and

(3) shall not require that no limit may be placed on total payments for such home care which is less than the limit (if

any) placed on total payments for inpatient hospital services related to the same condition.

(b) [Report.—The] *The* task force shall submit a final report, including the model provision, to the Director and to the Secretary within 18 months after the date of the enactment of this part. The report shall also be made available to the public.

MANDATORY INCLUSION OF HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN IN EMPLOYEE HEALTH BENEFIT PLANS

Sec. [2212.] *2312.* (a) [Determination of Degree of Voluntary Inclusion.—At] *At* the end of the 30th month following the date of the enactment of this part, the Secretary shall make a determination of the degree of voluntary inclusion in employee health benefit plans of coverage which is the same as, or substantially equivalent to (as determined by the Secretary), the model provision developed by the task force under section [2210.] *2311.* If the Secretary, in consultation with State insurance commissioners, determines that less than 80 percent of the employee health benefit plans, weighted by number of enrollees, include coverage which is the same as, or substantially equivalent to, such model provision, or if no such model provision has been developed, then the requirements of subsection (b) shall apply to all employee health benefit plans beginning with the January 1 next following the date of such determination.

[(b) Mandatory Inclusion.—]

[(1) In general.—In] *(b)(1) In* accordance with regulations which the Secretary shall prescribe, each employer shall include in any employee health benefit [plan,] *plan* coverage of home care for medical technology dependent children in accordance with this subsection.

(2) [Individuals eligible for home care.—The] *The* employee health benefit plan must provide coverage of home care in lieu of inpatient hospital services for all medical technology dependent children (as defined in section [2213)] *2313)* who—

(A) are covered under the employee health benefit plan for inpatient hospital services;

(B) would, but for the provision of such home care, require inpatient hospital services for a period one month or longer; and

(C) qualify for such home care under the criteria established by paragraph (3).

(3) [Criteria for home care.—Home] *Home* care shall be available to an individual in lieu of inpatient hospital services at the option of the individual's parent or legal guardian if—

(A) such home care is medically appropriate and in the best interests of the individual;

(B) such home care is approved by a physician, and appropriate medical backup is available;

(C) necessary services are available for care in the home; and

(D) the individual's family or legal guardian wishes to, and is able to, provide or assure the provision of adequate care in the home.

(4) [LIMITATIONS ON COVERAGE.—An] *An* employee health benefit plan may limit coverage of home care for medical technology dependent children (with respect to number of days, deductibles, and coinsurance) to the same extent that such plan places similar limits on coverage of inpatient hospital services.

(C) [DEFINITION OF HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN.—Subject] *Subject* to the limitation in subsection (b)(4), for purposes of this part, the term "home care for medical technology dependent children" means services required for extended intensive home care of a medical technology dependent child in lieu of inpatient hospital services, as determined by the Secretary, and may include services of a type not otherwise covered under the employee health benefit plan. Such services may include (but are not limited to)—

(1) medical and nursing services, including home visits;

(2) any medical devices, intravenous fluids, drugs, and supplies, which would be covered under the employee health benefit plan if furnished to an inpatient in a hospital;

(3) case management services;

(4) support services, including respite care and the services of a home health aide;

(5) rehabilitation services, including social work, physical therapy, occupational therapy, and speech therapy;

(6) transportation when required in order for the individual to receive necessary services away from home; and

(7) community-based or institutional services provided outside the individual's home when it is in the best interests of the individual to receive such services in a setting other than the home, but only to the extent such services would be covered under paragraphs (1) through (5) if provided in the home.

MEDICAL TECHNOLOGY DEPENDENT CHILD

SEC. [2213.] *2313.* For purposes of this title, the term "medical technology dependent child" means an individual under the age of 21 who has a medical condition (specified by the Secretary in regulations) which would require inpatient hospital services in the absence of home or community-based care, and who is dependent upon medical technology in order to avoid death or serious injury.

EMPLOYEE HEALTH BENEFIT PLAN

SEC. [2214.] *2314.* (a) [IN GENERAL.—For] *For* purposes of this part, the term "employee health benefit plan" means any plan of, or contributed to by, an employer to provide medical care (as defined in section 213(d) of the Internal Revenue Code of 1954) to its employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.

[(b) EMPLOYER.—(1)] *(b)(1)* For purposes of this part, the term "employer" means, except as otherwise provided in paragraph (2)—

(A) any employer (other than a State or political subdivision thereof)—

(i) which is required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but the section 13(a) of such Act); and

(ii) which during such calendar quarter employed an average of 25 or more employees;

(B) any State, or political subdivision thereof, which during any calendar quarter employed an average of 25 or more employees; and

(C) the Government of the United States, or any agency or instrumentality thereof, including the United States Postal Service and the Postal Rate Commission.

(2) The term "employer" does not include a church, convention or association of churches, or any organization operated, supervised, or controlled by a church or convention or association of churches, which organization is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954.

PENALTIES

Sec. [2215.] *2315.* (a) [State or Local Governments.—The] *The* Secretary shall apply penalties to States and political subdivisions for violations of section [2212] *2312* in the same manner as penalties are authorized under section 1310(g) for violations of section 1310(a).

"(b) [Private-Employees.—The] *The* Secretary shall apply penalties to employers for violations of section [2212] *2312* in the same manner as penalties are authorized under section 1310(e) for violations of section 1310(a).

"COLLECTIVE BARGAINING AGREEMENTS

"Sec. [2216.] *2316.* No employer shall be required to pay more for health benefits as a result of the application of this part than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees, entered into prior to the date of the enactment of this part.".

(b) [Effective-Date.—Title] *Title* [XXII] *XXIII* of the Public Health Service Act shall become effective on the date of the enactment of this Act.

AMENDMENTS TO RELATED PROVISIONS OF LAW

Sec. 3. (a) [Federal Employees Health Benefits.—Section] *(1)(A) Section* 8904 of title 5, United States Code, is amended by inserting "(a)" before "The benefits", and by adding at the end thereof the following new subsection:

"(b) All plans must provide for home care for medical technology dependent children in accordance with the model coverage provision developed under section [2211] *2311* of the Public Health Service Act, or, if applicable, in accordance with section [2212] *2312* of such Act.".

(B) Subsection (a) of such section (as redesignated by subparagraph (A) of this paragraph) is amended by striking out "this section" each place it appears in paragraphs (3) and (4) and the matter

following paragraph (4) and inserting in lieu thereof "this subsection".

(2) Section 8903 of such title is amended—

(A) by striking out "section 8904(1) of this title" in paragraph (1) and inserting in lieu thereof "subsection (a)(1) of section 8904 of this title and the benefits described in subsection (b) of such section.";

(B) by striking out "section 8904(2) of this title" in paragraph (2) and inserting in lieu thereof "subsection (a)(2) of section 8904 of this title and the benefits described in subsection (b) of such section";

(C) by striking out "section 8904(3) of this title" in paragraph (3) and inserting in lieu thereof "subsection (a)(3) of section 8904 of this title and the benefits described in subsection (b) of such section"; and

(D) by striking out "section 8904(4) of this title" in paragraph (4)(A) and inserting in lieu thereof "subsection (a)(4) of section 8904 of this title and the benefits described in subsection (b) of such section".

(3) Section 8803a(b)(2) of such title is amended—

(A) by inserting "subsection (a) of" before "section 8904"; and

(B) by striking out "or both" and inserting in lieu thereof ", or both, and the benefits described in subsection (b) of such section".

(b) [CHAMPUS PROGRAM.—]Section 1077 of title 10, United States Code, is amended by adding at the end thereof the following new subsection;

[(e)] *(d)* Home care for medical technology dependent children must be provided under section 1076 of this title in accordance with the model coverage provision developed under section [2211] *2311* of the Public Health Service Act, or, if applicable, in accordance with section [2212] *2312* of such Act.".

(c) [EFFECTIVE DATE.—The] *The* amendments made by this section shall become effective on January 1, 1987.

EVALUATION

SEC. 4. The Secretary of Health and Human Services shall monitor and evaluate the implementation of the amendments made by this Act with respect to—

(1) the number of medical technology dependent children receiving home care in lieu of inpatient hospital services for various categories of medical conditions, such as conditions requiring a respirator, conditions requiring intravenous medication or nutrition, and neuromuscular deficits:

(2) the costs of home care and the costs of inpatient hospital care for various categories of medical conditions requiring medical technology; and

(3) the health status of medical technology dependent children receiving home care and of medical technology dependent children receiving inpatient hospital services for various categories of medical conditions.

VI. Tabulation of Votes in Committee

In Executive Session of the Committee on Labor and Human Resources on Wednesday, March 19, 1986, the Chairman offered S. 1793, as introduced on October 25, 1985.

Senator Grassley offered two amendments to the bill. The first amendment was a clarification of grant recipients in the bill which would 1) give preference to Title V agencies for systems development grants and 2) give preference to academic medical centers and children's hospitals for training and technical assistance grants. This amendment passed by voice vote without dissent.

The second amendment was to delete the portion of the bill which mandates insurance coverage of home health care benefits for medical technology dependent children. This amendment failed on rollcall vote. The recorded vote is as follows:

YEAS	NAYS
Hatch	Stafford
Quayle	Hawkins
Thurmond	Weicker
Wallop	Kennedy
Grassley	Pell
Nickles	Metzenbaum
	Matsunaga
	Dodd
	Simon
	Kerry

Hatch ordered reported S. 1793, as amended, favorably to the Senate. Motion agreed to, 13 yeas, 3 nays.

YEAS	NAYS
Hatch	Quayle
Stafford	Wallop
Nickles	Grassley
Hawkins	
Thurmond	
Weicker	
Kennedy	
Pell	
Metzenbaum	
Matsunaga	
Dodd	
Simon	
Kerry	

VII. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 17, 1986.

Hon. ORRIN G. HATCH,
Chairman, Committee on Labor and Human Resources, U.S. Senate,
Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 1793, the Alternatives to Hospitalization for Medical Technology Dependent Children Act of 1985, as ordered reported by the Senate Committee on Labor and Human Resources on March 19, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes.

Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1793.
2. Bill title: Alternatives to Hospitalization for Medical Technology Dependent Children Act of 1985.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on March 19, 1986.
4. Bill purpose: To amend the Public Health Service Act to establish a grant program to develop improved systems of caring for medical technology dependent children in the home, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Estimated authorization levels:					
Grants	20.0	20.0	20.0	20.0	20.0
OTA study		0.3	0.2		
Total estimated authorization level	20.0	20.3	20.2	20.0	20.0
Estimated outlays:					
Grants	11.3	17.5	19.4	20.0	20.0
OTA study		0.3	0.2		
Total estimated outlays	11.3	17.8	19.6	20.0	20.0

The costs of this bill fall within function 550.

Basis of estimate: The authorization level for home care system development grants is stated in the bill. CBO assumes that all authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays for the grant are estimated using spendout rates computed by CBO for the Maternal and Child Health (MCH) block grant. Agencies administering the MCH program would be given preference in receiving the new grant money authorized in the bill.

No authorization level was stated in the bill for the eighteen month task force to be appointed by the Office of Technology Assessment (OTA). The task force would develop a model insurance provision for coverage of home care for medical technology dependent children. CBO estimates full costs for the task force could be about $500,000.

The bill could eventually require employee health benefit plans to provide coverage for home care services for medical technology dependent children. Coverage would become mandatory if less than 80 percent of employee health benefit plans voluntarily include home care provisions within two and a half years of the bill's enactment.

The budgetary impact of the mandatory insurance coverage provision is difficult to determine. Key information about federal expenditures and private insurance coverage for medical technology dependent children is currently unknown. If this provision is triggered, services for children needing mechanical ventilation or intravenous treatment, for example, would be covered in some part by private insurance. Insurers, however, could limit home care coverage to the same extent as inpatient hospital services. Any costs or savings that may accrue to the federal government as a result of this bill would depend on the extent to which the federal government currently pays for these services and the extent to which federal support would be offset by private insurance coverage.

Total federal dollars spent on care for medical technology dependent children is unknown. Some inpatient hospital care for medical technology dependent children could be currently paid for by the federal government through either the Medicaid program or the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Medicaid program provides medical benefits to certain low-income families that are categorically needy or to medically needy families with qualifying income after medical expenses. Medical technology dependent children in low-income or near low-income families most likely have all of their inpatient hospital care currently paid for by Medicaid, as providers are required to accept Medicaid reimbursements as payment in full for care for these children. Some states also allow Medicaid coverage for families with incomes in excess of eligibility levels if a member of the family is hospitalized for an extended period of time or if the family incurs medical expenses that cause them to "spend down" to the state's eligibility standard. In addition, some states provide Medicaid coverage for home and community based services so that some medical technology dependent children could be currently receiving care at home paid for by Medicaid.

The CHAMPUS program provides medical benefits for military retirees, dependents and spouses of active duty and retired military employees and to survivors of military employees. CHAMPUS would currently cover some portion of inpatient care for medical technology dependent children of current or former military employees. The child's family would pay a small part of the cost of inpatient care at a uniformed service medical facility and could pay an even larger portion of the costs if the child is treated in a hospital that does not accept CHAMPUS reimbursements as payment in full. Since CHAMPUS does not provide coverage for domiciliary care as do some Medicaid state programs, all medical technology dependent children covered by CHAMPUS would be currently treated in the hospital.

Under the bill, children whose care is currently paid for through the Medicaid or CHAMPUS programs could begin to be covered by private insurance policies. Savings could accrue to the federal government to the extent that private health plans pay a portion of the cost of home care for medical technology dependent children that the federal government otherwise would have paid. However, both the Medicaid and CHAMPUS Programs are secondary payors of medical expenses. The federal government could continue to pay for a smaller portion of these children's care not covered by private insurance if the family still meets federal eligibility requirements.

In order for this bill to result in savings for the federal government, families with medical technology dependent children must first have private health insurance and second, choose the option of caring for their children at home. The bill would give parents or guardians the choice of caring for a child at home if such care is approved by a physician, if the necessary home care services are available, and if assurance of adequate care can be provided. CBO has no basis to estimate how many of these families currently have private insurance, would be insured in the future, or would choose to care for their children at home.

Potential costs or savings to both the federal government and to state and local governments could result to the extent that health insurance premiums rise or fall as a result of mandatory home care coverage for these children. The federal government, through the Federal Employees Health Benefits Program, and state and local governments are employers, and therefore purchasers of health benefits for their employees. If insurance premiums were to change due to enactment of this bill, it would affect the price that governments pay for these benefits.

Several studies that will provide additional information on medical technology dependent children are currently being conducted. Three of these studies in particular, will provide information on federal costs and private insurance coverage for these children. Dr. Dorothy Guyot, Dr. Arnold Birenbaum, and Dr. Herbert Cohen at the Albert Einstein College of Medicine in New York run the Health Care Finance Project, studying children's health care utilization. Part of their study will focus on ventilator assisted children—the frequency of care they receive, the cost of their care, and who pays for it. Findings will be complete in about two years. Evaluation of Ventilator Assisted Children and Home Care Programs in Illinois, Louisiana, and Maryland is a study being conducted at the University of Chicago by Dr. LuAnn Aday and Marlene Aitken. This study will also include a survey of ventilator assisted children and their health care costs. The final report for this study is due in February 1987. The Office of Technology Assessment (OTA) is conducting a study on home care for technology dependent children as requested by the Senate Committee on Labor and Human Resources and the House Committee on Energy and Commerce. A draft report of OTA's findings is expected sometime this summer.

6. Estimated cost to State and local governments: The budgets of state and local governments could be affected if health insurance

premiums change as a result of enactment of this bill. CBO currently has no basis to estimate whether premium rates would change or the magnitude or direction of such a change. Since states pay for 45 percent of the costs of the Medicaid program, their budgets could also be affected by changes in Medicaid payments for these children. Again, the direction and magnitude of this change is unknown.

7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: Carmela Dyer.
10. Estimate approved by: C.G. Nuckols for James L. Blum, Assistant Director for Budget Analysis.

VIII. SECTION-BY-SECTION ANALYSIS

Section 1 of this bill cites its short title as the "Alternatives to Hospitalization for Medical Technology Dependent Children Act of 1985."

Section 2 of the bill amends the Public Health Service Act by adding at the end of that Act a new title: Title XXII—Home Care For Medical Technology Dependent Children.

New section 2201(a) of the Public Health Service Act allows the Secretary of Health and Human Services to make grants to:

(1) establish and maintain, through collaborative efforts with other agencies and individuals, systems of home and community-based services which provide alternatives to hospitalization for medical technology dependent children.

(2) provide training for individuals who give care to medical technology dependent children.

(3) provide technical assistance to agencies which provide care to medical technology dependent children.

New section 2201(b) allows these grants to be made to State agencies administering Maternal and Child Health programs under Title V of the Social Security Act, which relate to medical technology dependent children, academic medical centers, and children's hospitals.

New section 2201(c) requires the Secretary of Health and Human Services to establish the procedures for applying for these grants.

New section 2201(d) authorizes an appropriation of $20 million for each fiscal year beginning with FY 1986 in order to make grants under this section.

New section 2201(a) requires the Director of the Congressional Office of Technology Assessment to appoint a taskforce to develop a model provision for coverage of home health care for medical technology dependent children under employee health benefit plans. This model must:

(1) specify services to be covered;

(2) limit expenditures for home care to the amount that would be spent if care were given in a hospital setting; and

(3) insure that all limits placed on total payments to home care be not less than those placed on total payments to inpatient hospital services for the same condition.

New section 2210(b) requires the taskforce to submit a report to the Director of the Congressional Office of Technology Assessment and the Secretary of Health and Human Services within 18 months of the appointment of the taskforce. The report must be available to the public.

New section 2212(c) requires the Secretary of Health and Human Services, 30 months after the enactment of this bill, to determine the degree to which coverage of home care for medical technology dependent children has been voluntarily included in employee health benefit plans. If the Secretary in consultation with state insurance officials determines that less than 80 percent of the employee health benefit plans contain coverage of home care for medical technology dependent children similar to the model provision, then mandatory inclusion of coverage by all employee health benefit plans (as described in (b) of this section) would be required. Mandatory inclusion of coverage would also be required if no model provision is developed. Coverage would become mandatory beginning on the January 1 following the date the determination is made.

New section 2212(b)(1) requires each employer to include home care for medical technology dependent children in employee health benefit plans in accord with regulations prescribed by the Secretary.

New section 2212(b)(2) specifies that employer health plans are required to cover home care in lieu of inpatient hospital services for all medical technology children who:

(A) are covered under the health benefit plan for inpatient hospital services;

(B) would require inpatient hospital services for one month or longer if not for the provision of home care; and

(C) are eligible for home care under the criteria established in (b)(3) of this section.

New section 2212(b)(3) requires that home care be available in lieu of inpatient hospital care at the option of the individual's parent or legal guardian if:

(A) it is medically appropriate and in the best interest of the individual;

(C) the home care is approved by a physician and appropriate medical backup is available;

(C) the services necessary for care in the home are available; and

(D) the family or legal guardian of the individual receiving the care desires to and is able to provide care in the home.

New section 2212(b) 4 permits the employee benefit plan to limit coverage of home care (with respect to number of days, deductibles, and coinsurance) in the same ways that coverage is limited for hospital inpatients services provided under the plan.

New Section 2212(c) defines "home health care for technology dependent children" as services required for extended intensive home care of a medical technology dependent child in lieu of hospital inpatient services, as determined by the Secretary. These services may include services not otherwise covered under the employee benefit plan. Although the bill would not preclude other services from being offered under an employee health benefit plan, the following services may be included:

(1) medical and nursing services, including home visits:

(2) medical devices, intravenous fluids, drugs and supplies, that are covered under the employee health benefit plan if furnished to an inpatient in a hospital;

(3) case management services;

(4) support services, including respite care and the services of a home health aide;

(5) rehabilitation services, including social work, physical therapy, occupational therapy, and speech therapy;

(6) transportation when required in order for the individual to receive services away from home; and

(7) limited community-based or institutional services when it is necessary that the individual receive services away from home but only to the extent that would be covered under items (1) through (5) if the individual were receiving this care at home.

New section 2213 defines "medical technology dependent child" as any person under 21 who has a medical condition (as specified by the Secretary of Health and Human Services in regulations) requiring inpatient hospital services in the absence of home care or community-based health care and who is dependent on medical technology in order to avoid death or severe injury.

New section 2214(a) defines "employee health benefit plan" as any plan of an employer that provides medical care for its employees (as defined in section 213(d) of the Internal Revenue Code of 1954), former employees, or the families of such employees, or former employees, directly or through insurance, reimbursement or otherwise.

New section 2214(b) defines "employer" as:

(A) any nongovernmental employer which:

(i) must pay its employees the minimum wage according to the Fair Labor Standards Act of 1938 during any calendar quarter; and

(ii) has an average of 25 or more employees in that calendar quarter;

(B) any State or local government which employed an average of 25 employees or more in any calendar quarter;

(C) The Government of the United States or any agency or instrumentality of it.

For the purpose of this bill the term "employer" would not include churches, conventions or associations of churches, or organizations operated, supervised, or controlled by churches, their conventions or associations of churches which are described in Sec. 501(c) of the Internal Revenue Code of 1954.

Now section 2215(a) describes the penalties that would be applied to State or local governments which violate the provisions of the section 2212. Governments that do not comply would be subject to the penalties authorized under section 1310(g) of the Public Health Service Act for State and local governments failing to provide for membership in a qualified Health Maintenance Organization as an option under their employee health benefit plans. These include the termination of payment to States of funds under sections 314(d), 317, 318, 1002, 1525 and 1613 of the Public Health Service Act.

New section 2215(b) describes the penalties applied to private employers who violate new section 2212. These employers would be subject to the penalties authorized under section 1310(e) of the Public Health Service Act for private employers failing to provide for membership in a qualified Health Maintenance Organization as an option under their employee health benefit plans. The penalty would be limited to a civil penalty of up to $10,000 with an additional civil penalty for every 30-day period of continued noncompliance.

New section 2216 specifies that an employer would not have to pay more for health benefits as a result of the application of this part than it would have paid under any prevailing collective bargaining agreement or legal contract between the employer and employee entered into before the enactment of this bill.

New section 2216(b) sets the effective date for this new title at the date of its enactment.

Section 3(a) of this bill would amend the Federal Employees Health Benefits (FEHB) statute, section 8904 of title 5, United States Code, by requiring that all employee health benefit plans provide home care for technology dependent children in accordance with the model coverage provision developed under section 2211 of the Public Health Service Act, or if applicable, in accordance with section 2212 of that Act.

Section 3(b) of this bill amends the CHAMPUS program, section 1077 of title 10, United States Code, to require that home care for medical technology dependent children be covered under section 1076 of title 10 in accordance with the model coverage provision developed under new section 2211 of the Public Health Service Act, or if applicable, in accordance with section 2212 of that Act.

Section 3(c) of this bill sets the effective date of the amendments to the FEHB and CHAMPUS programs at January 1, 1987.

Section 4 of this bill requires the Secretary of Health and Human Services to monitor and evaluate the implementation of the amendments made by this Act. Under this section, the Secretary is required to maintain information on:

(1) the number of medical technology dependent children receiving home care in lieu of inpatient hospital services for various categories of medical conditions;

(2) the cost of home care and hospital care for various categories of medical conditions requiring medical technology;

(3) the health status of the children receiving home care and the health status of those receiving inpatient hospital services for various categories of medical conditions.

IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Public Health Service Act

TITLES I—XXII * * *

TITLE XXIII—HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN

Part A—Grants Relating to Home Care for Medical Technology Dependent Children

GRANTS RELATING TO HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN

Sec. 2301. (a) The Secretary shall make grants for the purposes of—

(1) establishing and maintaining, through collaborative efforts with other interested agencies, institutions, organizations, groups, and individuals, systems of safe and effective home and community-based services which provide alternatives to hospitalization for medical technology dependent children (as defined in section 2313);

(2) providing training for individuals who provide care to medical technology dependent children; and

(3) providing technical assistance to agencies, institutions, and organizations which provide care to medical technology dependent children.

(b) Grants under this section may be made to State agencies administering programs under title V of the Social Security Act which relate to medical technology dependent children, academic medical centers, and children's hospitals. In making grants under paragraphs (1) and (3) of subsection (a), preference shall be given to State agencies administering programs under title V of the Social Security Act. In making grants under paragraph (2) of subsection (a), preference shall be given to academic medical centers and children's hospitals.

(c) The Secretary shall establish procedures for applying for grants under this section.

(d) For purposes of making grants udner this section there are authorized to be appropriated $20,000,000 for each fiscal year, beginning with fiscal year 1986.

Part B—Requirements for Employee Health Benefits Plans

DEVELOPMENT OF MODEL COVERAGE PROVISION

Sec. 2311. (a) The Director of the Congressional Office of Technology Assessment shall appoint a task force for the purpose of developing a model provision for coverage of home care for medical technology dependent children (as defined in section 2313) under employee health benefit plans. The model—

(1) shall specify services which must be covered for such children;

(2) shall not require expenditures for home care which are greater than those which would be made if care for the same condition were rendered in a hospital setting; and

(3) shall require that no limit may be placed on total payments for such home care which is less than the limit (if any) placed on total payments for inpatient hospital services related to the same condition.

(b) The task force shall submit a final report, including the model provision, to the Director and to the Secretary within 18 months after the date of the enactment of this part. The report shall also be made available to the public.

MANDATORY INCLUSION OF HOME CARE FOR MEDICAL TECHNOLOGY DEPENDENT CHILDREN IN EMPLOYEE HEALTH BENEFIT PLANS

SEC. 2312. (a) At the end of the 30th month following the date of the enactment of this part, the Secretary shall make a determination of the degree of voluntary inclusion in employee health benefit plans of coverage which is the same as, or substantially equivalent to (as determined by the Secretary), the model provision developed by the task force under section 2311. If the Secretary, in consultation with State insurance commissioners, determines that less than 80 percent of the employee health benefit plans, weighted by number of enrollees, include coverage which is the same as, or substantially equivalent to, such model provision, or if no such model provision has been developed, then the requirements of subsection (b) shall apply to all employee health benefit plans beginning with the January 1 next following the date of such determination.

(b)(1) In accordance with regulations which the Secretary shall prescribe, each employer shall include in any employee health benefit plan coverage of home care for medical technology dependent children in accordance with this subsection.

The employee health benefit plan must provide coverage of home care in lieu of inpatient hospital services for all medical technology dependent children (as defined in section 2313) who—

(A) are covered under the employee health benefit plan for inpatient hospital services;

(B) would, but for the provision of such home care, require inpatient hospital services for a period of one month or longer; and

(C) qualify for such home care under the criteria established by paragraph (3).

(3) Home care shall be available to an individual in lieu of inpatient hospital services at the option of the individual's parent or legal guardian if—

(A) such home care is medically appropriate and in the best interests of the individual;

(B) such home care is approved by a physician, and appropriate medical backup is available;

(C) necessary services are available for care in the home; and

(D) the individual's family or legal guardian wishes to, and is able to, provide or assure the provision of adequate care in the home.

(4) An employee health benefit plan may limit coverage of home care for medical technology dependent children (with respect to number of days, deductibles, and coinsurance) to the same extent

that such plan places similar limits on coverage of inpatient hospital services.

(c) Subject to the limitation in subsection (b)(4), for purposes of this part, the term "home care for medical technology dependent children" means services required for extended intensive home care of a medical technology dependent child in lieu of inpatient hospital services, as determined by the Secretary, and may include services of a type not otherwise covered under the employee health benefit plan. Such services may include (but are not limited to)—

(1) medical and nursing services, including home visits;

(2) any medical devices, intravenous fluids, drugs, and supplies, which would be covered under the employee health benefit plan if furnished to an inpatient in a hospital;

(3) case management services;

(4) support services, including respite care and the services of a home health aide;

(5) rehabilitation services, including social work, physical therapy, occupational therapy, and speech therapy;

(6) transportation when required in order for the individual to receive necessary services away from home; and

(7) community-based or institutional services provided outside the indivudal's home when it is in the best interests of the individual to receive such services in a setting other than the home, but only to the extent such services would be covered under paragraphs (1) through (5) if provided in the home.

MEDICAL TECHNOLOGY DEPENDENT CHILD

SEC. 2313. For purposes of this title, the term 'medical technology dependent child' means an individual under the age of 21 who has a medical condition (specified by the Secretary in regulations) which would require inpatient hospital services in the absence of home or community-based care, and who is dependent upon medical technology in order to avoid death or serious injury.

EMPLOYEE HEALTH BENEFIT PLAN

SEC. 2314. (a) For purposes of this part, the term 'employee health benefit plan' means any plan of, or contributed to by, an employer to provide medical care (as defined in section 213(d) of the Internal Revenue Code of 1954) to its employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.

(b)(1) For purposes of this part, the term "employer" means, except as otherwise provided in paragraph (2)—

(A) any employer (other than a State or political subdivision thereof)—

(i) which is required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act); and

(ii) which during such calendar quarter employed an average of 25 or more employees;

(B) any State, or political subdivision thereof, which during any calendar quarter employed an average of 25 or more employees; and

(C) the Government of the United States, or any agency or instrumentality thereof, including the United States Postal Service and the Postal Rate Commission.

(2) The term "employer" does not include a church, convention or association of churches, or any organization operated, supervised, or controlled by a church or convention or association of churches, which organization is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954.

PENALTIES

SEC. 2315. (a) The Secretary shall apply penalties to States and political subdivisions for violations of section 2312 in the same manner as penalties are authorized under section 1310(g) for violations of section 1310(a).

(b) The Secretary shall apply penalties to employers for violations of section 2312 in the same manner as penalties are authorized under section 1310(e) for violations of section 1310(a).

COLLECTIVE BARGAINING AGREEMENTS

SEC. 2316. No employer shall be required to pay more for health benefits as a result of the application of this part than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees, entered into prior to the date of the enactment of this part.

OTHER ACTS AFFECTED BY THIS LEGISLATION

UNITED STATES CODE

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TITLE 5—GOVERNMENT ORGANIZATION AND EMPLOYEES

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CHAPTER 89—HEALTH INSURANCE

Secs. 8901-8902 * * *

Sec. 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by [section 8904(1) of this title] *subsection (a)(1) of section*

8904 of this title and the benefits described in subsection (b) of such section, given to employees, annuitants, members of their families or former spouses, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, or former spouse.

(2) INDEMNITY BENEFIT PLAN.—One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in exess of the actual expenses incurred, for benefits of the types described by [section 8904(2) of this title,] *subsection (a)(2) of section 8904 of this title and the benefits described in subsection (b) of such section.*

(3) EMPLOYEE ORGANIZATION PLANS.—Employee organization plans which offer benefits of the types referred to by [section 8904(3) of this title,] *subsection (a)(3) of section 8904 of this title and the benefits described in subsection (b) of such section,* which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) COMPREHENSIVE MEDICAL PLANS.—

(A) GROUP-PRACTICE PREPAYMENT PLANS.—Group-practice prepayment plans which offer health benefits of the types referred to by [section 8904(4) of this title,] *subsection (a)(4) of section 8904 of this title and the benefits described in subsection (b) of such section,* in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

* * * * * * *

Sec. 8903a. Additional health benefits plans

(a) In addition to any plan under section 8903 of this title, the Office of Personnel Management may contract for or approve one or more health benefits plans under this section.

(b) A plan under this section may not be contracted for or approved unless it—

(1) is sponsored or underwritten, and administered, in whole or substantial part, by an employee organization described in section 8901(8)(B) of this title;

(2) offers benefits of the types named by paragraph (1) or (2) of *subsection (a) of* section 8904 of this title [or both;], *or both, and the benefits described in subsection (b) of such section;*

* * * * * * *

Sec. 8904. Types of benefits

(a) The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) SERVICE BENEFIT PLAN.—

(A) Hospital benefits.
(B) Surgical benefits.
(C) In-hospital medical benefits.
(D) Ambulatory patient benefits.
(E) Supplemental benefits.
(F) Obstetrical benefits.

(2) INDEMNITY BENEFIT PLAN.—
(A) Hospital care.
(B) Surgical care and treatment.
(C) Medical care and treatment.
(D) Obstetrical benefits.
(E) Prescribed drugs, medicines, and prosthetic devices.
(F) Other medical supplies and services.

(3) EMPLOYEE ORGANIZATION PLANS.—Benefits of the types named under paragraph (1) or (2) of this [section] *subsection* or both.

(4) COMPREHENSIVE MEDICAL PLANS.—Benefits of the types named under paragraph (1) or (2) of this [section] *subsection* or both.

All plans contracted for under paragraphs (1) and (2) of this [section] *subsection* shall include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature.

(b) All plans must provide for home care for medical technology dependent children in accordance with the model coverage provision developed under section 2311 of the Public Health Service Act, or, if applicable, in accordance with section 2312 of such Act.

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TITLE 10—ARMED FORCES

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CHAPTER 55—MEDICAL AND DENTAL CARE

Secs. 1071-1076 * * *

Sec. 1077. Medical care for dependents: authorized care in facilities of uniformed services

(a)-(c) * * *

(d) Home care for medical technology dependent children must be provided under section 1076 of this title in accordance with the model coverage provision developed under section 2311 of the Public Health Service Act, or, if applicable, in accordance with section 2312 of such Act.

* * * * * * *

ADDITIONAL VIEWS OF MESSRS. QUAYLE, WALLOP, AND GRASSLEY

We are compelled to register our strong opposition to S. 1793, the "Alternatives to Hospitalization for Medical Technology Dependent Children Act of 1985". We voted against reporting this bill out of the Senate Labor and Human Resources Committee and, if the bill is taken up on the floor, we plan to move to recommit the bill for further study.

While we understand and sympathize with the plight of children and their families who would be better served by home care instead of institutionalization, we believe that this course of action is necessary and appropriate because:

1. The bill raises substantial constitutional questions. (See Appendix I for opinions from the Department of Justice, the Senate Legal Counsel and the Congressional Research Service.)
2. Interested parties which would be substantially affected by the mandated benefits provision in the bill have not had the opportunity to present their views to the Committee (labor unions, the insurance industry, State and local governments, private sector employers).
3. The bill mandates changes in programs under the jurisdiction of other committees: The CHAMPUS Program under the Senate Armed Services Committee and the Federal Employees Health Benefits (FEHB) Program under the Senate Governmental Affairs Committee.
4. The bill mandates health insurance coverage for a population of "medical technology dependent children" which is ill-defined and for which there is not a credible size estimate.
5. The bill makes a major change in Federal-State relations concerning the regulation of health insurance without any serious exploration of the implications of this step.

We do not believe that a bill with so many unresolved issues is appropriate for consideration on the floor. It is the responsibility of the Committee to explore and resolve such matters before it reports legislation and we believe that the Labor and Human Resources Committee should be given another opportunity to consider these issues.

1. Constitutional Concerns

Constitutional concerns were raised at the executive session about those provisions of S. 1793 requiring the Office of Technology Assessment to appoint a task force for the purpose of developing a model provision for coverage of home health care for medical technology dependent children under employee health plans. If after one year of the development of this plan, 80% of employers do not include the model provision or coverage which is deemed to be substantially equivalent, then the Secretary of the Department of Health and Human Services must establish regulations requiring the employers covered in the bill to provide a home health care benefit for this population.

Concerns were raised that the model plan is in legal effect a delegation of legislative authority because the Secretary is required to use it to determine whether the 80% standard is met. Specifically, it was argued that the bill contained both an unconstitutional delegation of power to a legislative agency and to private citizens since it was clearly the intention of the Committee that the task force consist of private sector representatives. Yet despite these concerns and the suggestion of the Chairman of the Committee that action on the bill should be delayed pending a legal opinion of these issues, the Committee approved the bill. Several legal opinions have confirmed that there are indeed constitutional problems with the bill as reported.

2. Lack of a Hearing Record

In general, the legislative process—most particularly when the legislation is controversial—includes a hearing on the relevant issues or on the bill itself. While this Committee did hold a hearing on pediatric home health care on June 18, the hearing record does not reflect a discussion of the mandated benefit issue. Further, many of the parties who will be affected by this legislation—employers, unions, state and local governments, insurers, representatives of the FEHB and the CHAMPUS programs were not given the opportunity to testify on their concerns.

We are not saying that this Committee should hold a hearing on every bill or on every amendment to a bill. However, we are saying that when issues are controversial and precedent setting, all affected parties should have an opportunity to make their views known so that the members of this Committee will not be legislating in the dark.

3. Jurisdiction

This legislation clearly impinges upon the jurisdictional responsibilities of the Committees with responsibility for the CHAMPUS Program and the Federal Employees Health Benefits Plan, the Armed Services Committee and the Governmental Affairs Committee respectively, by requiring these plans to offer a pediatric home health care benefit.

We believe legislating in this fashion is inappropriate. The Committees with the expertise in the program should have been consulted to determine if such a benefit was necessary. Further, the cost implications and the priorities of these programs should have been considered.

4. Eligible Population

Another question relates to the population which would be eligible to receive the mandated insurance coverage. How many children fit into the definition of the medical technology dependent child outlined in the bill? What situations would this definition cover?

Currently, the Office of Technology Assessment is—at the request of the Congress—attempting to develop a workable definition of a medically technology dependent child and to assess the magnitude of this population. Thus, we must ask, why are we legislating without this information? It should also be noted that in this same study the Office of Technology Assessment is also attempting to assess:

> The current availability of insurance coverage for institutional and home care for these children.
>
> The current sources of funding for services delivered to these children by setting of care.
>
> The net costs to private and public payers and to patients' families in providing coverage for services delivered to these children in the home.

In addition, included in the recently enacted, "Consolidated Omnibus Budget Reconciliation Act of 1985", P.L. 99-232, is a mandate to the Secretary of Health and Human Services to establish a task force concerning alternatives to institutional care for technology-dependent children. This task force is charged with: identifying barriers that prevent the provision of appropriate care in a home or community setting and; recommending changes in the provision and financing of health care so as to provide home and community-based alternatives to the institutionalization of technology-dependent children. Given these ongoing efforts to gather the most basic information about this population, it is irresponsible to pass legislation before most of the facts are in and the necessary first steps have been taken.

5. IMPLICATIONS OF ALTERING STATE JURISDICTION OVER INSURANCE

During the markup on this bill, it was argued that the real question was whether we wanted to protect these children. We contend that the issue is hardly that simplistic nor are the parameters of the debate that narrow.

Traditionally, the states have had the responsibility for regulating insurance. Within this context the states have passed over 600 mandated benefit laws related to health care. (See Appendix II). Our contention is that should the Congress decide that this is an appropriate subject for Federal regulation, certain questions need to be answered. Chief among these are to what extent have mandated benefits at the state level eroded employees' access to basic health care coverage and/or increased their costs for such coverage? There is some concern that the growth in mandated benefits is reaching the point where they are squeezing out basic coverage.

We believe it is important to look at the precedent Congress would be setting if this legislation is enacted. How is Congress going to deal with similar requests in the future? Is it really more worthwhile to mandate pediatric home health care benefits than coverage for organ transplants, dental benefits and so forth? Do mandated "special interest" benefits make sense when some health plans are lacking in coverage for maternity and other "basic" benefits? Do they make sense in light of growing concerns over the need for catastrophic coverage? In short, we seriously question whether the Committee has adequately considered what its priorities should be and whether this area is appropriate for Federal legislation.

For these reasons we intend to move to recommit the bill.

DAN QUAYLE.
MALCOLM WALLOP.
CHARLES E. GRASSLEY.

APPENDIX I.

U.S. Department of Justice

Office of Legislative and Intergovernmental Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

MAY 16 1986

Honorable Dan Quayle
United States Senate
Washington, D.C. 20510

Dear Senator Quayle:

You have requested the Department's views on the constitutionality of S. 1793, "The Alternatives to Hospitalization for Medical Technology Dependent Children Act of 1985." Specifically, you have asked whether section 2211[1] contains an unconstitutional delegation of legislative authority, either to a legislative agency or to private citizens. For the reasons set forth below, we conclude that, in light of the bill's other provisions, the task force that would be created under section 2211 would be unconstitutional.

S. 1793 would amend the Public Health Services Act by creating an elaborate mechanism to require employee health benefit plans[2] to cover home care for medical technology dependent children[3] on an equal basis with hospital care.[4] Section 2211 requires the Director of the Congressional Office of Technology Assessment ("Director") to "appoint a task force for the purpose of developing a model provision for coverage of home care for medical technology dependent children...." Sec. 2211(a). Among other requirements, this model provision is to "specify services which must be covered for such children." Sec. 2211(a)(1).[5] Together with a "final report" of unspecified content, the model is to be submitted to the Director, the Secretary of Health and Human Services, and the public. Sec. 2211(b).

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[1] As the bill is currently numbered, there is no section 2211 -- the bill skips from 2210 to 2212. In a telephone conversation of April 25, 1986, Mary McGrane of your office informed us that this was simply a typographical error. Since section 3 of the bill apparently refers to section 2210 as 2211, and since this would require less "renumbering" in the present context than any other solution, we uniformly refer to the section beginning on page 3, line 13 as section 2211.

[2] The bill would reach plans provided by employers which, during any calendar quarter are covered by section 6 of the Fair Labor Standards Act, and which employed an average of 25 or more employees during such calendar quarter. It would also reach the United States, as well as any State, or political subdivision thereof, which employed an average of 25 or more employees during any calendar quarter. Sec. 2214. While we do not elaborate on the point, we believe that the extension of this bill to state and local governments may disregard Congress' affirmative responsibility to be sensitive to the reserved powers of the states. Garcia v. San Antonio Metropolitan Transit Authority, 105 S.Ct. 1005, 1018-1020 (1985).

Section 2212(a) provides that if, after 30 months, less than 80% of employee health benefit plans provide coverage which is the same as, or substantially equivalent to, that of the model provision, then the Secretary is to prescribe regulations governing all employee health benefit plans, in accordance with the standards set forth in section 2212.

Section 2212 gives legal effect to the model drafted under section 2211, by requiring the Secretary to use it as the sole criterion for determining whether to issue further regulations. Moreover, sections 3(a) and (b) of the bill would amend 5 U.S.C. 8904, as well as 10 U.S.C. 1077, to include home care "in accordance with the model coverage provision developed under section 2211...or, if applicable...section 2212...." In other words, if the task force's model provision is adopted by at least 80% of employee health benefit plans, then the model itself will automatically become law as part of 5 U.S.C. 8904 and 10 U.S.C. 1077.

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[3] As defined in section 2213, a medical technology dependent child "means an individual under the age of 21 who has a medical condition (specified by the Secretary in regulations) which would require inpatient hospital services in the absence of home or community-based care, and who is dependent upon medical technology in order to avoid death or serious injury."

[4] The bill would also establish a grant program to develop means of caring for medical technology dependent children at home. Sec. 2201.

[5] The model provision is also to provide that covered expenditures for home care must be equal to, but not greater than, those for hospital care. Sec. 2211(a)(2) and (3).

We believe that the authority which is vested in the task force by section 2211 arguably could be characterized as either predominantly legislative or predominantly executive. If it is seen as legislative, then the provision is unconstitutional under the Presentment Clause. Under Art. I, sec. 7, cls. 2 & 3 of the Constitution, measures intended to be binding exercises of legislative power must be adopted by majorities of both Houses of Congress and presented to the President for his approval or disapproval. This plenary legislative power may not be delegated to a task force, a committee, or to one house of Congress. See INS v. Chadha, 103 S.Ct. 2764 (1983). Thus, to the extent S. 1793 seeks to bestow upon a task force the discretion to legislate on the nature and content of employee health benefit plans, it is unconstitutional under the Presentment Clause.[6]

In your letter, you state that it is the committee's intention that the task group which would draft the model provision be composed of private citizens.[7] If it were, you inquire as to whether this would represent an unconstitutional delegation of legislative authority. We are very hesitant to advance the delegation doctrine as an argument against a bill's constitutionality. The current status of that doctrine is quite uncertain; the Supreme Court has not struck down a statute under the delegation doctrine in fifty years. See generally, Synar v. United States, No. 85-4106, slip op. at 14-17 (D.D.C. Feb. 7, 1986). Instead, since 1936, the Court has consistently rejected such arguments. See, e.g., United States v. Mazurie, 419 U.S. 544, 556-557 (1975); United States v. Sharpnack, 355 U.S. 286, 297

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[6] We do not believe that Congress may evade the Presentment Clause merely by prospectively codifying whatever the task force may later decide.

[7] The legislation does not define the membership of the task force.

(1958). Consequently, we believe the Presentment Clause provides a stronger argument.[8]

In the alternative, the task force's powers might be viewed as predominantly executive or regulatory in nature. If so, then the exercise of such authority by the task force would constitute a violation of the Appointments Clause (Art. II, sec. 2, cl. 2).[9] The Appointments Clause provides that Officers of the United States must be appointed by the President, by and with the advice and consent of the Senate, or where authorized by statute, by the President alone, or by the Courts or Heads of Departments. They may not be appointed by Congress or by Congressional officers. Buckley v. Valeo, 424 U.S. 1, 126 (1976).

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[8] On the other hand, the Court has continued to refer to the delegation doctrine in construing statutes so as to uphold their constitutionality. See, e.g., Industrial Union Dept. v. American Petroleum Institute, 448 U.S. 607, 646 (1980)(Opinion of Stevens, J.)(construing Occupational Safety and Health Act); National Cable Television Assoc. v. United States, 415 U.S. 336,342 (1974)(construing Independent Office Appropriation Act).

Moreover, we do wish to note that section 3 of S. 1793 does appear to contain an alarming delegation of authority. Under section 3, once the task force's model provision is adopted by at least 80% of employee health benefit plans, the model itself automatically becomes statutory law as part of 5 U.S.C. 8904 and 10 U.S.C. 1077. This goes far beyond giving even regulatory power to private citizens. Simply stated, the bill would, under the stated conditions, codify the discretion of private citizens. In this sense, section 3 seems far more extreme than the statute struck down under the delegation doctrine in A.L.A. Schechter Poultry Corp. v. United States, 295 U.S. 495 (1935). In Schechter, the Court invalidated legislation which required private trade or industrial associations to draft "codes of fair competition," and submit them to the President, who was empowered to approve them. 295 U.S. at 522-523. (The President could also unilaterally modify the proposed codes, or promulgate his own codes, sua sponte. See 295 U.S. at 523.) Once approved, the codes had the force of law, and violations were punishable as a criminal offense. Id. In striking down the statute, the Court emphasized both the lack of enunciated standards to guide the formulation of the codes, and the fact that the codes were to be drafted by private citizens. 295 U.S. at 537-539. However, in Schechter, the privately-drafted codes were to acquire legal effect only upon approval by the President. Under S. 1793, the model provision would receive legal effect independent of further legislative or executive action. Nevertheless, the judicial erosion of the delegation doctrine casts considerable doubt on whether even this rather extreme delegation of authority to private citizens would be found unconstitutional as a violation of the delegation doctrine, instead of simply being held to be a violation of the Presentment Clause.

Whether a person must be an officer of the United States in the constitutional sense depends upon his statutory duties. A person who exercises significant authority pursuant to the laws of the United States must be such an officer, and must therefore be appointed pursuant to Article II, sec. 2, cl. 2 of the Constitution. Buckley, supra, 424 U.S. at 126, 141.

In promulgating the model provision, the task force would clearly be exercising significant authority pursuant to the laws of the United States. In the first instance, they would decide which services must be covered under employee health benefit plans. See Sec. 2211(a)(1). Moreover, the Secretary would be required to base his determination of whether to issue further regulations solely on the criteria established by the task force's model provision. See Sec. 2212. In order to validly exercise this type of regulatory authority, we believe the members of the task force would have to be officers of the United States, appointed in accordance with the Appointments Clause. Consequently, their appointment by the Director of the Congressional Office of Technology Assessment would be unconstitutional.

In sum, we believe that S. 1793 may not constitutionally create a task force to draft a "model" insurance provision, and then give that provision the force of law. This is true regardless of whether the task force members are private citizens or members of Congress, and regardless of whether the task force's duties are characterized as legislative or executive.

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[9] Moreoever, if the task force were to include members of Congress, their service on it would violate the Incompatibility Clause (Art. I, sec. 6, cl. 2), which provides: "No Senator or Representative shall, during the Time for which he was elected, be appointed to any civil Office under the Authority of the United States, which shall have been created, or the Emoluments whereof shall have been encreased during such time; and no Person holding any Office under the United States, shall be a Member of either House during his Continuance in Office."

Sincerely,

John R Bolton

John R. Bolton
Assistant Attorney General

MICHAEL DAVIDSON
COUNSEL
KEN U. BENJAMIN, JR.
DEPUTY COUNSEL
MORGAN J. FRANKEL
ASSISTANT COUNSEL

PHONE: 202-224-4435

United States Senate
OFFICE OF SENATE LEGAL COUNSEL
WASHINGTON, DC 20510

March 27, 1986

Mr. William J. Ryan
Chief Counsel
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Bill:

As I mentioned during our telephone conversation earlier this week, the legislative history of the Act which established this office indicates that the Senate was reluctant to confer on us the authority to issue formal opinions on the constitutionality of pending legislation. Our role on issues of constitutionality comes after enactment, when we represent the Senate in cases in which the executive branch disputes the constitutionality of Acts of Congress.

I believe that I can relate to you, nevertheless, an experience which may be germane to the committee's consideration of S. 1793. In December 1979, the Congress passed and sent to the President a bill, S. 2096 of the 96th Congress, which directed the Secretary of Health, Education and Welfare to study the long-term health consequences of dioxins. The bill provided that the HEW Secretary could undertake the study only after the Office of Technology Assessment approved the study's protocol. President Carter vetoed the bill on the ground that this power "may not constitutionally be delegated to ... offices subordinate to committees of the Congress." 1980-81 Pub. Papers (Jimmy Carter) at 5. The veto message noted that the President had signed previous legislation delegating similar power to OTA to approve the protocol of a Veterans Administration study, and that the President was "instructing the VA Administrator not to treat that provision as legally binding." Id. The Senate did not attempt to override the veto. The validity of the President's objections was confirmed subsequently by the Supreme Court's decision in Immigration and Naturalization Service v. Chadha, 462 U.S. 919 (1983).

An alternative model for issuing regulations or standards following a congressionally directed study may be found in 42 U.S.C. § 300g-1 (1982). There, Congress directed the EPA Administrator to enter into arrangements with the National Academy of Sciences, or with another independent scientific organization if appropriate arrangements could not be made with NAS, to determine maximum drinking water contaminant levels necessary to meet public health requirements. The statute vested in the EPA Administrator the power to issue a rule to establish recommended maximum contaminant levels which, "in the Administrator's judgment based on such report," id., § 300g-1(b)(1)(B), were required to meet the public health objectives of the Act. In this way, the Congress mandated that the Administrator's action be "based" on an independent scientific report but the Congress also permitted the Administrator to exercise his "judgment" in issuing a final rule.

I hope that this information is of assistance to you. As requested, your copy of the transcript of the Committee's March 19, 1986 meeting is enclosed.

Sincerely,

Michael Davidson

Enclosure

cc: Thomas M. Rollins

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

April 11, 1986

To: Senate Committee on Labor and Human Resources

From: American Law Division

Subject: Role of Office of Technology Assessment in S. 1793, a Bill to Improve Systems of Caring for Medical Technology Dependent Children in the Home

This memorandum briefly highlights a possible constitutional question that might be raised with respect to the role of the Office of Technology Assessment in S. 1793, 99th Cong., 1st Sess., a bill that would amend the Public Health Service Act to, among other things, insure that employee health benefit plans contain provisions for coverage of home care for children who are dependent upon medical technology in order to avoid death or serious injury.

Part B of a new Title XXII of the Public Health Service Act, 42 U.S.C. 201 et seq., would require the Director of the Office of Technology Assessment (OTA) to appoint a task force to develop a "model provision of home care for medical technology dependent children (as defined in section 2213) under employee health benefit plans." The model provision is to (1) specify services which must be covered for such children; (2) not require expenditures for home care that are greater than those which would be made if care for the same condition were rendered in a hospital; and (3) require that no limit may be placed on total payments for such home care which is less than the limit (if any) placed on total payments for inpatient hospital services related to the same condition. The model provision and accompanying report are to be submitted to the OTA Director and Secretary of Health and Human Services within 18 months of enactment of the bill.

At the end of 2 1/2 years following the enactment of the bill, the Secretary is to determine "the degree of voluntary inclusion in employee health benefit plans of coverage which is the same as, or substantially equivalent to (as determined by the Secretary), the model provision developed by the [OTA] task force..." If the Secretary, in consultation with state insurance commissioners, determines that less than 80% of the employee health plans include coverage which is the same as, or substantially equivalent to, the model provision, then certain statutory requirements are to be imposed on such health plans, in accordance with secretarial regulations. The statutory requirements would mandate coverage in employee health benefit plans of home care for medical technology dependent children, define individuals eligible for home care, and set forth criteria for home care. The statute would also define the term "home care for medical technology dependent children" in terms of the types of services to be covered.

The OTA is a support agency of the Congress "within and responsible to the legislative branch of the Government." 2 U.S.C. 472(a). It is governed by a Board consisting of Members of the House and the Senate and a Director appointed by the Board. 2 U.S.C. 473(a), 474(a). The OTA is thus solely an arm of Congress. Vesting in the OTA the authority to influence or force action of an executive officer, therefore, raises the specter of the type of congressional action found unconstitutional by the Supreme Court in INS v. Chadha, 462 U.S. 919 (1983). The Court in Chadha struck down the so-called legislative veto under which one or both Houses of Congress could reverse or halt executive action without passing a law. The Court's opinion was sweeping, holding that

Congress could not take "action that had the purpose and effect of altering the legal rights, duties, and relations of persons, including the Attorney General, Executive Branch officials and Chadha, all outside the Legislative Branch" except by means of passing a bill and presenting that bill to the President for his approval or veto. 462 U.S. at 952. Similarly, it would seem to follow that OTA, solely an arm of Congress, could not be delegated the power to take such actions with respect to the duties of executive officers.[1]

The question posed by S. 1793 is to what extent OTA is given the power to effect secretarial action. The model health care benefit provision developed by the OTA task force does not become the one imposed on employee health care plans if the Secretary makes the determination that voluntary compliance has not been adequate. The statute itself outlines what must be included in employee health plans with respect to home care of children dependent on medical technology and it delegates to the Secretary the authority to promulgate implementing regulations. The OTA model provision is merely the one that the Secretary is to use in assessing whether employers have voluntarily included in their employee health plans provisions that are "the same as, or substantially equivalent to" the model provision. However, it is the Secretary who is to make the judgment whether employee plans are equivalent to the OTA model. Thus, while the OTA model influences secretarial action and is to be employed as a standard under which secretarial determinations are to be made, the Secretary retains significant discretion in how he factors the OTA model into his compliance determination. Furthermore, the statute outlines with some specificity what is to be included in the OTA model provision, although the task force is free to specify what medical services must be covered in any such provision. Nevertheless, the Secretary may still make the judgment that a particular health plan provision is "substantially equivalent" to the model provision and is not bound strictly to the terms of the model provision.

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[1] Alternative formulations of the constitutional objection to such a scheme can also be made. The Court in Buckley v. Valeo, 425 U.S. 1 (1974) held that Congress could not vest significant duties under public law in an entity composed of individuals appointed by Congress, in that case, the Federal Election Commission (since reconstituted). Similarly, the delegation of executive functions to the Comptroller General has been challenged. The court in Ameron, Inc. v. United States Corps of Engineers, Nos. 85-5226 & 85-5377 (3rd Cir. March 27, 1986) held that the Comptroller General could be vested with the authority to stay the issuance of government contracts while considering the protests of unsucessful bidders. On the other hand, the District Court in Synar v. United States, C.A.No. 85-3945 (D.D.C. Feb. 7, 1986), prob. juris. noted sub nom., Bowsher v. Synar, 54 USLW 3561 (1986), struck down the trigerring mechanism in the Gramm-Rudman-Hollings deficit reduction act on the ground that Congress vested what the court viewed as executive powers in an agent of Congress, the Comptroller General.

The Comptroller General, while removable by joint resolution of Congress, is, nevertheless, appointed by the President. The OTA, on the other hand, is composed of Members and appointees of Congress. If the Comptroller General cannot be the repository of certain functions, a fortiori OTA may not be delegated such functions. Given the fact that OTA is virtually an alter ego of Congress, it would seem that the rationale of Chadha is the more appropriate constitutional standard under which to judge the validity of vesting functions in OTA that have the effect of forcing or influencing action by an executive officer. A more general theme that emerges from the above cases is that Congress -- either itself or through its agents -- may not impermissibly share in the execution of the laws.

Given the retention of some discretion in the Secretary in how he treats the OTA model provision, it is difficult to unequivocally condemn the scheme on the grounds outlined above. The OTA role does contain characteristics of the type of congressional action struck down in Chadha. On the other hand, the OTA findings, while not purely advisory, do not have the same action-forcing significance as that in Chadha and Synar.

Nevertheless, it is likely that the Department of Justice may view the OTA role as invalid. In 1980, it opined that a provision in a veterans bill, under which OTA was to dictate the protocol for an HEW study of the health effects of dioxin, constituted an unconstitutional legislative veto. The opinion was rendered prior to Chadha, but that case, if anything, bolstered the general legal theory relied on by the Department. The OTA role was objected to by the Department even though the ultimate study to be conducted pursuant to the OTA protocol was designed to merely advise Congress on the issue.[2] The role envisioned for OTA in S. 1793, while not much different than an advisory role (given the Secretary's ability to exercise judgment in his compatibility determinations), would seem to carry with it more impact outside the legislative branch than that in the above veterans study provisions. The Department's objections to the latter provisions therefore likely presage similar arguments being raised regarding S. 1793.

Richard Ehlke
Specialist in American
Public Law
April 11, 1986

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[2] The disputed provision was eventually dropped from the bill in the House on germaneness grounds. See, 126 Cong. Rec. 27391 (1980). For background on the Department's arguments, see, 126 Cong. Rec. 653-664 (1980); Letter to Chairman Cranston from Assistant Attorney General Parker, April 22, 1980 (on file at CRS). The President had vetoed an earlier version of the bill on the grounds advanced by the Department. See, 16 Weekly Comp. Pres. Docs. 4 (January 7, 1980). The previous year, provision for a similar study to be conducted pursuant to an OTA-approved protocol was approved. Public Law 96-151, 93 Stat. 1097 (1979). The President explained that he signed that bill because it contained needed appropriations authorizations and other necessary provisions. However, he instructed the Veterans Administration Administrator to treat the OTA approval provision as not legally binding. 16 Weekly Comp. Pres. Docs. 2 (January 7, 1980).

APPENDIX II.

MANDATED COVERAGE LAWS
ENACTED THROUGH 1985

Prepared by: BCBSA
Office of Government Relations
State Services
March 1, 1986

MANDATED COVERAGES

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA
NURSES										
Nurse Midwives		83	85				84		83	
Nurse Practitioners			85				84			
Nurse Anesthetists			85				84			
THERAPISTS										
Physical							75			
Occupational					78		82			
Speech/hearing				**85**	78					
COUNSELORS										
Psychologists	82		83	75	**80**	79	75			80
Psychiatric Nurses					82		84			
Social Worker					76		79			
DENTISTS	75	83	77		76		75			
ORAL SURGEONS										
OPTOMETRISTS	67	83			**80**		75	X*	74	
PODIATRISTS	76			75	76			X*	74	
CHIROPRACTORS	75	83	83		76		71	X*	**76**	80
OSTEOPATHS		83								
OTHER				75	76		75/84			
ALCOHOLISM	79		79		**78**	**76**	74/77		79	
DRUG ABUSE			79				76		79	
MENTAL HEALTH			79	**83**	**73**	**76**	75/82		**76/83**	81/8
BREAST RECONSTRUCTION			**81**	**78**	**78**					
MATERNITY				76	**76**	**75**	76			78
PRESCRIPTION DRUGS							75			
ORTHOTIC AND/OR PROSTHETIC DEVICES					**85**					
CLEFT PALATE										
DIABETIC EDUCATION					**81**					
DIABETIC OUTPATIENT										
SECOND OPINION										
HOME HEALTH			82		**78**	**84**	75/76			
HOSPICE						**84**	76			
AMBULATORY SURGERY			71						77	
ANTI-ABORTION						**85**	82			
PUBLIC INSTITUTIONS										
AMBULANCE/TRANSPORT FOR NEWBORNS										
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							82			79
ADOPTED CHILDREN			85						85	
NEWBORNS	75	75	74	75/83	71	75	74	76	80/84	74
MENTALLY/PHYSICALLY HANDICAPPED			77	**69**	71		71		70	72
PREVENTIVE CARE FOR CHILDREN/INFANTS					**74**					
NON-CUSTODIAL CHILDREN							84			
CONVERSION PRIVILEGE			85	79/85	83		75			
SURVIVORS			85		76		75			81
DIVORCED SPOUSE			85	85	76		76			80
DISABLED EMPLOYEE					77				75	
CATASTROPHIC COVERAGE										
POOL										
CONTINUATION				85	**84**					
CONTRACT REPLACEMENT					77					

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

03/01/8

MANDATED COVERAGES

	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD
NURSES										78
Nurse Midwives								84		78
Nurse Practitioners										79
Nurse Anesthetists										
THERAPISTS										
Physical										
Occupational										
Speech/hearing										
COUNSELORS										
Psychologists	84			85		74		75	75	73
Psychiatric Nurses									83	83
Social Worker						**82**			83	77
DENTISTS	74			74		73		74	75	
ORAL SURGEONS										
OPTOMETRISTS			80	74	**83**	73			82	73
PODIATRISTS			81	74		73				73
CHIROPRACTORS				74		73	**80**	75	86	73
OSTEOPATHS										73
OTHER			82							
ALCOHOLISM				76			**78**	**80**	**74**	82 80
DRUG ABUSE						**78**		**80**	83	78
MENTAL HEALTH			**74/77**			**78**		**75**	79/83	73/75
BREAST RECONSTRUCTION			80							
MATERNITY	74								75	75
PRESCRIPTION DRUGS									83	
ORTHOTIC AND/OR PROSTHETIC DEVICES										78
CLEFT PALATE		85		85						82
DIABETIC EDUCATION					**84**					
DIABETIC OUTPATIENT										
SECOND OPINION										85
HOME HEALTH							**82**		77	79
HOSPICE										82
AMBULATORY SURGERY	74						78			
ANTI-ABORTION							78			
PUBLIC INSTITUTIONS										67
AMBULANCE/TRANSPORT FOR NEWBORNS								80		
OTHER HEALTH CENTERS				85					79	76
DEPENDENT STUDENTS								78		79
ADOPTED CHILDREN			81							79
NEWBORNS	74	74	75	76	74	74	**76**	73	76	
MENTALLY/PHYSICALLY HANDICAPPED	68	72	67	69				72		X
PREVENTIVE CARE FOR CHILDREN/INFANTS										
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE			83			78/80	74		82	79
SURVIVORS			85			84				77
DIVORCED SPOUSE			76			78/84	80			77
DISABLED EMPLOYEE	74	75							83	
CATASTROPHIC COVERAGE										78
POOL			82							
CONTINUATION			84			84	80	83		79
CONTRACT REPLACEMENT								77		

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

03/01/86

MANDATED COVERAGES

	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ
NURSES								85		84
Nurse Midwives			83	80			84			82
Nurse Practitioners				80					85	
Nurse Anesthetists			83	80						
THERAPISTS										
Physical										75
Occupational										
Speech/hearing					**84**					
COUNSELORS										
Psychologists	75	68*	75	74	83	81	74	80	75	73
Psychiatric Nurses										
Social Worker	82					85			**83**	
DENTISTS	75		73	74	78	83	75	75		79
ORAL SURGEONS		85							75	
OPTOMETRISTS			73	66	78		69	75		67
PODIATRISTS			73		78		69	75		
CHIROPRACTORS		79	73	80	78		67	82		80
OSTEOPATHS							67	75		
OTHER					78			75		
ALCOHOLISM	73	74/82	73/82	74	77/85	79	80	83		77
DRUG ABUSE		74/82	73/82		80	81		83		
MENTAL HEALTH	73/82		75		80	81			75/83	
BREAST RECONSTRUCTION		85	80					83		83
MATERNITY			73		73			77		
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES		85								
CLEFT PALATE										
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION										80
HOME HEALTH						**81**		75		
HOSPICE		**84**						83		
AMBULATORY SURGERY		84/85	76		75/81					
ANTI-ABORTION					83					
PUBLIC INSTITUTIONS			73			73	84			
AMBULANCE/TRANSPORT FOR NEWBORNS				79						
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							76			
ADOPTED CHILDREN	75		83							
NEWBORNS	74		73	74	74	73	75	76	75	75
MENTALLY/PHYSICALLY HANDICAPPED	56	66	69	72		71		76	69	66
PREVENTIVE CARE FOR CHILDREN/INFANTS										
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	76		77		81	81	78	80		
SURVIVORS			73		69		80	80	81	76
DIVORCED SPOUSE			77					80	81	80
DISABLED EMPLOYEE			73							82
CATASTROPHIC COVERAGE			76							
POOL						85	84			
CONTINUATION					85	81	79			
CONTRACT REPLACEMENT										

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

03/01/86

MANDATED COVERAGES

	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC
NURSES		**85**								
Nurse Midwives	85	82			84	71		82		
Nurse Practitioners				**84**			80			
Nurse Anesthetists										
THERAPISTS										
Physical		73								
Occupational										
Speech/hearing										
COUNSELORS										
Psychologists	77	71	77		74	71	76	78		
Psychiatric Nurses										
Social Worker		85								
DENTISTS	77	75			73	71	71			
ORAL SURGEONS										
OPTOMETRISTS	77	X			80	71	76	78		85
PODIATRISTS	77	X			80	71				72
CHIROPRACTORS	**84**	X	73	79	80	71		**81**		**80**
OSTEOPATHS	77				80					
OTHER	**85**									
ALCOHOLISM	**83**	82/83	**84**	75	78		75/81		80	
DRUG ABUSE			**84**	75						
MENTAL HEALTH		77		75	83		73			
BREAST RECONSTRUCTION		75								
MATERNITY		76			79		73			
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			82							
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION		76							83*	
HOME HEALTH	77	72/75							84*	
HOSPICE		**85**								
AMBULATORY SURGERY		X				76				
ANTI-ABORTION				79				82		
PUBLIC INSTITUTIONS			75		76					
AMBULANCE/TRANSPORT FOR NEWBORNS										
OTHER HEALTH CENTERS		X								
DEPENDENT STUDENTS										
ADOPTED CHILDREN										
NEWBORNS	75	77	73	79	74	**84**	75	76		74
MENTALLY/PHYSICALLY HANDICAPPED	69	65	69/73	**82**	71			**68**		70
PREVENTIVE CARE FOR CHILDREN/INFANTS		82								
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	83	71/81	82	83	75/**84**		77		78	78
SURVIVORS	83	**81**								
DIVORCED SPOUSE	83	81	83						83	78
DISABLED EMPLOYEE										
CATASTROPHIC COVERAGE									74	
POOL				84	84					
CONTINUATION										
CONTRACT REPLACEMENT										

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03/01/86

MANDATED COVERAGES

	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
NURSES							81			
Nurse Midwives	80			79			81	83		
Nurse Practitioners	80						81			
Nurse Anesthetists										
THERAPISTS										
Physical										
Occupational										
Speech/hearing			83							
COUNSELORS										
Psychologists		74	77	75		77				85
Psychiatric Nurses								77		
Social Worker		**85**		75		**79**				
DENTISTS		74	83						75	
ORAL SURGEONS										
OPTOMETRISTS		65	79	75		77			75	
PODIATRISTS		65	77	75		79	83		75	
CHIROPRACTORS		81	79	75		79*	**83**		76	
OSTEOPATHS			**58**			77				71
OTHER	80	82				77				
ALCOHOLISM	79	**79**	81	81	82/85	77/80	74	82	74/85	
DRUG ABUSE			81			77/80			74/85	
MENTAL HEALTH		**79/80**	81		76	76/77	**83**	77*	74/85	
BREAST RECONSTRUCTION							83/85			
MATERNITY		**84**	77			**78**			82	
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE										
DIABETIC EDUCATION									84	
DIABETIC OUTPATIENT				**84**					82	
SECOND OPINION										
HOME HEALTH					76		**83**		78	
HOSPICE							**83**			
AMBULATORY SURGERY				76						
ANTI-ABORTION										
PUBLIC INSTITUTIONS									80	75
AMBULANCE/TRANSPORT FOR NEWBORNS										
OTHER HEALTH CENTERS			83						75	
DEPENDENT STUDENTS										
ADOPTED CHILDREN	83			85						
NEWBORNS	76	74	73	77	76	76	74/84	75	76	75
MENTALLY/PHYSICALLY HANDICAPPED		69	81	75		74	69		75	71
PREVENTIVE CARE FOR CHILDREN/INFANTS										
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	79	80	77	79		82	84		80	83
SURVIVORS			79		84		80		80	
DIVORCED SPOUSE	80		79		84		80	83	80	
DISABLED EMPLOYEE							73	82	73	
CATASTROPHIC COVERAGE										
POOL						85		79		
CONTINUATION									80	
CONTRACT REPLACEMENT										

X = Year unknown

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Bold Print = Mandated offerings

03/01/86

MANDATED COVERAGES

Miscellaneous

AR - Outpatient Diagnostic; Licensed Health Professionals (75)

CA - Sterilization (70); Prenatal Care **(76,79)**; Child/Family Counselors (80,81); Acupuncture **(84)**; Psychiatric Health Facility (84)

CT - Notice of Termination (82); Nutropathic Medicine (75); most passed under comprehensive health care act of 1975; HMO Rehabilitation Facilities (82); Emergency Ambulance Services (83); Home Health Aides (84)

CO - Anti abortion mandate for state group only (85)

HI - Prepaid Health Care Plans (74)

ID - Complications of Pregnancy (76)

IL - Raped or Sexual Assault (75,82); Psychologists Mandated Through Regulation (76); Liver Transplants (84); All persons licensed under medical practice act are entitled to reimbursement if legally able to provide contract benefit (82)

KY - Newborn Nursery Care (80)

LA - Non-group to age 65 (74)

MD - Partial Psychiatric Hospitalization (76); Blood Products (75); All Providers (83); Orthopedic Braces (78); Invitro Fertilization (85); OP benefits resulting from UR programs (85)

MI - Non-group Medicare Complimentary Coverage (85); Mental Hospitals (83)

MS - Pre-existing Conditions (82)

MO - Pharmacists (78)

MT - Professional Counselors (85); Denturists (85)

NH - Pastoral Counselors (83)

NV - Chinese Medicine (75)

NJ - Diagnostic X-rays by Chiropractors (76)

NY - Pre-admission Testing (76); Ambulance Cancer Treatment (82); Nursing Home Option (X)

ND - Continued Coverage after HMO Selections (83)

NM - Practitioner Mandates of 1977 do not apply to Plan; Lay Midwives (85)

OH - OP Dialysis (72)

OR - Denturists (80)

SD - Reimburse all "Healing Arts" Practitioners (80); COB Prohibited (81)

TN - School Psychologists (82)

TX - OP Psychiatric Centers (83)

VA - Opticians (77); Termination Notice (82); Mandated Benefit Option (82)

WI - Tuberculosis; Skilled Nursing Homes (75); COB (80); Kidney Disease (74)
Insulin Infusion Pumps (81)

WY - Licensed Practitioners (71)

Calendar No. 658

99TH CONGRESS
2d Session

SENATE

REPORT
99-308

PRESIDENT'S COUNCIL ON HEALTH PROMOTION AND DISEASE PREVENTION

MAY 21 (legislative day, MAY 19), 1986.—Ordered to be printed

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Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 2057]

The Committee on Labor and Human Resources, to which was referred the bill (S. 2057) to establish the President's Council on Health Promotion and Disease Prevention, having considered the same, reports favorably thereon without amendment(s) and recommends that the bill as amended do pass.

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I. SUMMARY OF THE BILL

As reported by the Committee, S. 2057 would amend the Public Health Service Act (PHSA) to create a new section 1707. The new section would establish a President's Council on Health Promotion and Disease Prevention. The Council would: (1) advise the President on matters concerning the building and maintaining of the maximal personal health of Americans; (2) advise the President on

S543-10.

State, local, and private activities relating to health promotion and disease prevention; (3) encourage State and local governments and private entities in developing and conducting research and programs and activities concerning health promotion and disease prevention; (4) prepare an inventory of Federal, State, local, and private programs and activities for promotion of health and prevention of illness and injuries, particularly those directed toward subgroups of the population with special health risks; (5) assess which available health promotion and disease prevention resources are not fully used and how they might be better targeted toward subgroups with special health risks; and (6) make recommendations to the President concerning methods to inform the public about available health promotion and disease prevention resources and additional health promotion and disease prevention programs and activities which should be undertaken to improve the personal health of Americans.

The Council would, within 18 months after enactment of the bill, prepare and submit to the President and the Congress a report describing its activities.

The Council would be composed of fifteen members appointed by the President. Five members would be Federal, State, and local officers and employees, four would be representatives of academic institutions, and four would be representatives of public and private organizations. All of these first thirteen members would be required to have expertise and experience in health promotion or disease prevention. The final two members would represent the general public.

II. BACKGROUND AND NEED FOR LEGISLATION

One of the great accomplishments of the 20th century in the health field has been the virtual elimination of many infectious and communicable diseases. The United States has made remarkable progress in reducing the toll in death and disability from such diseases as polio, tuberculosis, diphtheria, typhoid fever, smallpox, and others.

These achievements have been based on knowledge obtained through research and then translated into prevention efforts such as improvements in sanitation, housing, nutrition, and immunization. As a result of these measures, as well as other improvements in the provision of health care, infant and child deaths have declined and life expectancy has increased.

The infectious and communicable diseases that previously took such a toll on life and health have been replaced in the latter half of the century by the major chronic diseases, such as heart disease, cancer, and stroke. At the present time, cardiovascular diseases, including heart disease and stroke, cause about half of all deaths in the U.S. Various forms of cancer account for about 20 percent of deaths. Among people below the age of 44, accidents have become the leading cause of death.

Changes in the major causes of death and disability call for changes in preventive health measures. The 1980s find us in the midst of a new revolution in the prevention of disease and the promotion of health. One of the things we have learned about the battle against the chronic diseases and other health problems that limit life today is that simply increasing expenditures for health will not in itself be enough to reduce the toll these diseases take.

Between 1960 and 1985, total expenditures for health in the U.S. increased from $27 billion to $438 billion, a sixteen-fold increase. Expenditures for health as a percentage of the gross national product doubled, from 5.3 percent to almost 11 percent.

Even with this increase in expenditures accompanied by improved access to, and quality of, medical care, certain problems remain. It has become clear that a few basic changes in behavior can bring about significant improvements in the health and productivity of our citizens. The impact of such diseases as heart disease, cancer, and stroke can be reduced or avoided through such changes in behavior as more exercise, improved diet, and reducing or eliminating the use of tobacco and alcohol. Simply fastening seatbelts would significantly reduce the death and disability caused by automobile accidents.

The contribution of health and promotion and disease prevention measures can be seen in the recent history of heart disease. In 1983, 38 percent of deaths in the U.S. were attributable to heart disease. Death rates from heart disease vary by race and sex, but it still remains the leading cause of death for all races and sex groups. Between 1950 and 1983 death rates for heart disease declined at a rate of almost 2 percent per year for women, both black and white. For men, however, heart disease mortality did not begin to decline until the late 1960s. Since that time, the mortality from heart disease for white males has declined at nearly the same rate as for females. For black males the decline has been at a slightly slower rate. Part of the reason for the decline in heart disease mortality has been improvement in the control of hypertension, a major risk factor for heart disease. Greater availability of coronary care units and advanced surgical and medical treatment of coronary heart disease are additional contributing factors in the decline. Finally, changes in personal health behavior, such as decreased smoking, modified eating habits, and increased exercise have been important factors in the steady decline in heart disease mortality.

Despite improvements over the past 30 years, there is still room for improvement. In 1983, age-adjusted death rates from heart disease were 20 percent higher for black males than for white males and 51 percent higher for black females than for white females. Sex differences are even higher. In 1983, the age-adjusted death rate for heart disease was more than twice as high for white males than white females and 61 percent higher for black males than black females.

Heart disease and stroke account for 31% more deaths among black males than white males and 14% more deaths among black females than white females. It is the leading category of "excess deaths" (where black rates are higher than rates in the population in general) which currently account for 47% of the total annual deaths in those blacks 45 years old or less, and 42% of deaths in those aged 70 years or less. Although life expectancy has increased twice as fast for black as for whites over the last 5 years, it is still at the level reached by whites in the mid 1950's.

An area of personal behavior closely related to the incidence of heart disease, as well as other diseases, is tobacco use. The Surgeon General has called cigarette smoking the most important preventable cause of disease and death in the U.S. Tobacco use is the major cause of lung cancer and is associated with coronary heart disease, arteriosclerotic peripheral vascular disease, chronic bronchitis, emphysema, and cancers of the larynx, oral cavity, esophagus, pancreas, and bladder. In addition, smoking in conjunction with other substances, such as oral contraceptives, alcohol, and asbestos, increase the risk of certain diseases.

In 1965, more than half of all men over age 20 smoked cigarettes on a regular basis compared with only about one third of adult females. Since that time, smoking among men has declined at a much greater rate than among females. As a result, the earlier sex differential has decreased substantially. In 1985, only about 33 percent of adult males were cigarette smokers, compared with 28 percent of adult females. The lack of decline among women smokers can be attributed to an increase in smoking among women 20 to 24 years of age. These women were teenagers in the 1970's where smoking among teenagers was increasing.

The result of the lack of decline in smoking among females can now be seen in part in the rapid rise in the death rate for lung cancer among women. Breast cancer has long been the leading cause of cancer deaths among women, leading other cancers by far. In 1950, for instance, the age-adjusted death rate for breast cancer among women was nearly five times that of lung cancer. In 1986, the age-adjusted death rate for lung cancer will become the number one cause of cancer death for women. If current trends continue, 1 of every 33 women will die of lung cancer.

Smoking during pregnacy is an important risk factor for low birth weight, with the incidence of low birth weight increasing steadily with the number of cigarettes smoked per day. Low birth weight accounts for two thirds of infant mortality. The proportion of married mothers 20 years and over who smoked during pregnancy has declined in recent years. Studies indicate that smoking among unmarried mothers is considerably higher than among married mothers. The disproportionately high smoking rate is one factor leading to the higher infant death rate for blacks.

In 1960, blacks suffered 44% infant deaths for every 1000 births, roughly twice the rate for whites 23%. In 1983, although the mortality rate for black infants has declined by more than 50% to 19 infant deaths per 1000 live births, this rate is still almost twice the white level of 10%, but similar to the white rate of 1965.

Most of the credit for the decreases in cigarette smoking over the past 2 decades can be given to the concerted health promotion and diseases prevention effort waged as a direct result of the 1965 Surgeon General's report on Smoking and Health. Legislation at the national level to require warning labels and to limit broadcast advertising as well as legislation at State and local levels to limit smoking in certain public places helped to enhance public information and education campaigns supported by a variety of public and private agencies and organizations to reduce both the public acceptability of smoking and the levels of smoking among most population groups.

The total cost to society of cigarette smoking has been placed at between $38 billion and $95 billion, with a middle estimate of $65 billion. That amounts to $2.17 in lost productivity and health care cost per package of cigarettes sold.

A similar legislative and public information campaign has recently begun in an effort to bring about a decrease in the use of smokeless tobacco products. The use of these products has increased alarmingly, particularly among adolescent boys and young men, who use such products under the misconception that they are a safe alternative to cigarettes. Increased attention to the use of smokeless tobacco has led to reports by the Surgeon General and the National Institutes of Health on the dangers of such use to health. Legislation originating in this Committee has been passed by the 99th Congress to educate the public on the health consequences of smokeless tobacco, P.L. 99-252.

The abuse of alcohol and of drugs is another preventable serious health problem in this country. The Department of HHS in 1985 estimated that, in 1980, the most recent year for which data were available, the economic burden of alcohol abuse and drug abuse on American society was over $136 billion. Included in these estimates are the direct costs for treatment and support and the indirect costs related to reduced economic productivity caused by drug and alcohol-related disorders. According to these estimates, prepared for the Department by the Research Triangle Institute, alcohol abuse contributed the largest share of these costs, at $89.5 billion. The cost of drug abuse was $46.9 billion.

One of the most serious disorders related to alcohol abuse, one that has only recently been scientifically documented, is Fetal Alcohol Syndrome (FAS). Since ancient times, alcohol use has been considered a risk to pregnancy. During the 18th century, a link between alcohol and birth defects was suspected. It was not until a report published in 1973 by researchers at the University of Washington cited a "characteristic pattern of malformation" in eight children of alcoholic mothers that a significant relationship between alcohol use during pregnancy and a variety of adverse fetal outcomes was firmly established and a name given to it. Thousands of clinical reports and experimental studies published in the years since have left little doubt that prenatal alcohol exposure poses a threat to the health of the unborn child, ranging from miscarriage and newborn death to a cluster of abnormalities classified as FAS, and to subtle behavioral disturbances such as hyperactivity, which may occur in the absence of observable physical abnormalities.

Reports of the prevalence of FAS vary widely and no firm national data are as yet available. Prevalance rates which have been obtained are limited to specific populations that have been studied and range in the U.S. from approximately one case to three cases per 1,000 live births. A prevalence of 9.8 cases per 1,000 has been observed among the high-risk American Indian population. Despite the lack of firm numbers on the prevalence of FAS, it is clear that for every child with identified FAS there are probably several others who have been affected by alcohol during pregnancy but who lack the full set of characteristics that define the disorder.

Until we know more about fetal alcohol syndrome all women should avoid alcohol use during pregnancy. This message should be emphasized to every woman who is pregnant or contemplating pregnancy.

Alcohol related mortality is a particular problem amongst minority groups. According to the Secretary's Task Force on Minority Health, Cirrhosis mortality rates have declined consistently among all race-sex groups in the United States since 1973, but they are still nearly twice as high among Black Americans. Blacks also have higher rates of other alcohol related health problems including esophageal cancer.

Teh 1979 National Institute of Alcohol Abuse and Alcoholism Survey indicates that Hispanic American males ages 18 and over higher levels of heavy drinking and higher rates of alcohol related problems that do nonminorities. The Indian Health Service reports that five of the top ten causes of death among Indians are directly related to alcohol: accidents (21%), cirrhosis of the liver (6%), alcoholism (3.2%), suicide (2.95%) and homicide (2%). These alcohol-related causes of death are more than three times higher among Native Americans than that of other groups.

More than 15.4 million American men (24.2%) and 18.6 million women (21.1%) between the ages of 20 and 74 fit the description of clinical obesity, according to the National Center for Health Statistics. For much of the low income population the problem, is not access to adequate calories, it is the food choices they make. Sixty percent of black women in this country between the ages of 45 and 64 are overweight according to the Health and Nutrition Examination Survey. Obesity increases the risk of heart attacks, strokes, and other cardio-vascular diseases while also causing musculoskeletal problems. Today, obesity has joined caloric deficiency as the leading nutritional disease for people below the poverty line.

One of the aspects of health promotion and disease prevention in which we have seen a major movement in recent years is the area of physical fitness and exercise. During the past decade or more, there has been a resurgence of interest in physical fitness and exercise. The health benefits that can be attained from regular exercise have not been fully assessed, but limited research knowledge suggests that appropriate physical activity can enhance approaches to treatment and prevention of such disorders as heart disease, obesity, hypertension, diabetes, musculoskeletal problems, stress, anxiety, and depression.

Both the public and private sectors play a significant role in encouraging and supporting exercise and fitness activities. A variety of physical fitness and health promotion activities are sponsored by employers for their employees at the worksite. Within the community itself, programs are offered by nonprofit public and private agencies and organizations as well as by companies for profit. Most schools provide physical education classes for their students.

The problem with this wide variety of fitness and exercise programs and opportunities is that not nearly enough Americans take advantage of them. Despite the benefits possible from regular exercise, evidence shows that Americans remain a relatively sedentary population. Recent surveys indicate that only about 35 percent of all adults age 18 to 65 in the U.S. exercise regularly. Only 33 percent of children participate in daily physical education programs, and 36 percent of persons over age 65 take regular walks.

It is clear that ther is considerable room for improvement in making exercise a regular part of every person's life. There is need for cooperative efforts from the public and private sectors to support research into the health and economic benefits of exercise and to increase the public's awareness of and participation in regular physical fitness and exercise activities.

Another area in which health promotion and disease prevention efforts can have an impact in reducing the cost in life and health in this country is accident prevention. More than 153,000 Americans die every year as a result of accidental injuries—nearly half from motor vehicle accidents and the rest from falls, burns, poisoning, and other causes. Injuries constitute this country's leading cause of death for persons in the first forty years of life and are the fourth leading cause of death for persons of all ages. Deaths caused by injuries are first in terms of years of life lost prematurely.

Accident victims are not distributed evenly throughout the population. The teenage and young adult population have the highest death rate from motor vehicle accidents. Two-thirds of all deaths for children and young adults aged 15–24 are caused by injuries. Fatal falls, occurring primarily in the home, affect the population aged 75 and over disproportionately. Children 10 and younger are at higher risk than older groups for burns. Certain behavioral and lifestyle choices influence and increase the probability of injury. Alcohol use, for example, is associated with approximately half of all deaths related to motor vehicle accidents, falls, fires and burns, and drownings. Careless handling of smoking materials by persons under the influence of alcohol contributes substantially to burn injuries and deaths.

Injuries and deaths from accidents can be reduced through a variety of prevention measures, including public education, skill development, safety engineering, environmental modification, legislation, regulation, and enforcement. The injury and death toll from motor vehicle accidents, for example, has received increased attention in recent years through public campaigns and State and national legislation, and other measures to reduce drunk driving and increase seat belt use.

The combined efforts of individuals, organizations, the public health and health care provider communities, governments at all levels, and the private sector will be needed to reduce injuries and the toll they take on our Nation.

The Congress and the Federal Government have been in the forefront of efforts to focus our Nation's attention on the importance of the promotion of health and the prevention of illness and injury as an integral part of an effective health care system and to stress the significance of individual lifestyle choices and personal responsibility as a part of successful health promotion and disease prevention efforts. In 1976, the National Consumer Health Information and Health Promotion Act, P.L. 94–317, established title XVII of the Public Health Service Act, Health Information and Health Promotion. Title XVII authorizes the Secretary of HHS to:

(1) Formulate national goals, and strategy to achieve such goals, with respect to health information and health promotion, preventive health services, and education in the appropriate uses of health care;

(2) Analyze the necessary and available resources for implementing those goals and strategies, and recommend appropriate educational and quality assurance policies for the needed manpower resources identified by such analysis;

(3) Undertake and support necessary activities and programs to incorporate appropriate health education components into all aspects of education and health care; increase the application and use of health knowledge, skills, and practice by the general population in its patterns of daily living; and establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health promotion concepts;

(4) Undertake and support research and demonstrations respecting health information and health promotion, prevention health services, and education in the appropriate use of health care;

(5) Undertake and support appropriate training in the operation of programs concerned with health information and health promotion;

(6) Undertake and support, through improved planning and implementation of tested models and evaluation of results, effective and efficient programs respecting health information and health promotion;

(7) Foster the exchange of information respecting research, demonstration, and training programs in health information and health promotion; and

(8) Create within the Department an Office of Health Information and Health Promotion to:

(i) Coordinate all activities within the Department which relate to health information and health promotion;

(ii) Coordinate its activities with similar activities of organizations in the private sector; and

(iii) Establish a national information clearinghouse to facilitate the exchange of information on health promotion.

In 1979, P.L. 97-79 extended the authority of title XVII for 3 years, through FY1982. P.L. 98-551, the Health Promotion and Disease Prevention Amendments of 1984, extended the authority of title XVII through FY1987. In addition, it authorized the establishment of a new Office of Disease Prevention and Health Promotion in the Office of the Assistant Secretary for Health to replace the Office of Health Information and Health Promotion created under the original title XVII.

The Office of Disease Prevention and Health Promotion coordinates Departmental policies and programs in health promotion and disease prevention. The Office disseminates health information to the public through the National Health Information Clearinghouse. In addition, the Office works to encourage health promotion and protection and preventive services in the public and private sectors through national public and voluntary organizations as well as business and industry.

Two major reports, published in 1979 and 1980, serve as the basis of the Department's ongoing effort in health promotion and disease prevention. "Healthy People," a report from the Surgeon General in 1979 on health promotion and disease prevention, outlined a national strategy in preventive health. This was followed a year later by "Promoting Health/Preventing Disease: Objectives for the Nation." This document provided specific and quantifiable objectives for each of 15 priority areas which had been identified in "Healthy People." Achievement of these objectives by 1990 or earlier has served as the focus of the Department's promotion/disease prevention effort, as monitored by the Office of Disease Prevention and Health Promotion.

III. HISTORY

The Committee has a long-standing interest in the importance of health promotion and disease prevention programs and activities as essential components of our national health policy. The Committee and its subcommittees have held numerous hearings in recent years on subject areas related to health promotion and disease prevention. In addition to the April 1983 hearings on the role of the Federal Government in the area of health promotion and disease prevention, other hearings on subjects related to this general area include Smoking and Health (May 1983), Drug Abuse Prevention and Education (April 1984), Longevity and Lifestyle of the Older Individual (September 1984), Osteoporosis (June 1985), Child Health and Fitness (September 1985), and Fitness and Nutrition (November 1985).

The Committee considered S. 2057 in executive session on March 19, 1986, and agreed to report it favorably to the Senate.

IV. TEXT OF BILL AS REPORTED

A BILL To establish the President's Council on Health Promotion and Disease Prevention

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "President's Council on Health Promotion and Disease Prevention Act of 1986".

ESTABLISHMENT OF COUNCIL

SEC. 2. Title XVII of the Public Health Service Act is amended by adding at the end thereof the following new section:

"PRESIDENT'S COUNCIL ON HEALTH PROMOTION AND DISEASE PREVENTION

"SEC. 1707. (a) There is established the President's Council on Health Promotion and Disease Prevention (hereafter in this section referred to as the 'Council').

"(b) The Council shall—

"(1) advise the President with respect to all matters concerning the building and maintaining of the maximal personal health of Americans;

"(2) advise the President with respect to State, local, and private activities relating to health promotion and disease prevention;

"(3) encourage State and local governments and private entities in the development and conduct of research relating to, and programs and activities to foster, health promotion and disease prevention;

"(4) prepare an inventory of Federal, State, local, and private programs and activities for promotion of health and the prevention of illness and injury, particularly programs and activities directed toward subgroups of the American population who have special risks to health;

"(5) assess which of the available health promotion and disease prevention resources are not being fully used by Americans and how such resources may be better targeted toward the subgroups described in paragraph (4); and

"(6) make recommendations to the President concerning—

"(A) appropriate methods to make available to the public information concerning available health promotion and disease prevention resources, including information concerning the programs and activities included in the inventory prepared under paragraph (4); and

"(B) additional health promotion and disease prevention programs and activities which should be undertaken to improve the personal health of Americans.

"(c) The Council shall be composed of fifteen members appointed by the President, of which—

"(1) five shall be Federal, State, and local officers and employees who have expertise and experience in health promotion or disease prevention;

"(2) four shall be representatives of academic institutions who have expertise and experience in health promotion or disease prevention;

"(3) four shall be representatives of public and private organizations who have expertise and experience in health promotion or disease prevention; and

"(4) two shall be representatives of the general public.

"(d) Members shall be appointed for the life of the Council. A vacancy in the Council shall be filled in the same manner as the original appointment was made.

"(e) The President shall designate a member of the Council as Chairperson.

"(f) The Council shall meet at the call of the Chairman.

"(g) Eight members of the Council shall constitute a quorum, but a lesser number may hold hearings. A vacancy in the Council shall not affect its powers.

"(h) Each member of the Council shall serve without compensation. While away from their homes or regular places of business in the performance of services for the Council, all members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under section 5702 of title 5, United States Code.

"(j)(1) The Secretary shall appoint and fix the compensation of an Executive Director for the Council. The Executive Director shall be an individual who has expertise and experience in health promotion or disease prevention. The Secretary shall provide the Council with such additional personnel, and with such additional support services and facilities, as the Secretary considers necessary to enable the Council to carry out its functions.

"(2) Any Federal employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(k)(1) The Council may, for the purpose of carrying out this section, hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence, as the Council considers appropriate.

"(2) The Council may secure directly from any department or agency of the United States information necessary to enable the Council to carry out this section. Upon request of the Chairman of the Council, the head of such department or agency shall furnish such information to the Council.

"(3) The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

"(l) Within eighteen months after the date of enactment of this section, the Council shall prepare and transmit to the President and the Congress a report which describes the activities of the Council under this section.

"(m) The Council shall terminate at the earlier of—

"(1) eighteen months after the date of enactment of this section; or

"(2) thirty days after the date on which the President and the Congress receive the report of the Council pursuant to subsection (l).".

V. Committee Views

The Labor and Human Resources Committee reports S. 2057 as a timely and promising measure. This legislation would establish at the highest level of government, a President's Council on Health Promotion and Disease Prevention for a period of 18 months. This high level, independent council will look for ways to increase the cost effectiveness, access, quality, and impact of American health care services through disease prevention.

During 1985, Americans spent nearly $438 billion, $1.2 billion per day, for health care. Yet, two of every three deaths in this country were premature. Most of these deaths could have been prevented through appropriate use of preventive services and behavior changes. As the percentage of our population over 65 years of age continues to grow, the demands placed on the health care system, and the financial burden placed on society, will continue to escalate.

Heart disease, cancer, and stroke-our number 1, 2, and 3 causes of death-still take an incredible toll in our society, annually costing an estimated 1.6 million lives and $137 billion in medical care and lost productivity. The total cost to society of substance abuse in approximately $250 billion per year. Alcohol abuse cost approximately $140 billion, cigarette use approximately $65 billion, and other substance abuse approximately $40 billion. In 1983 there were approximately 1 million teenage pregnancies costing societies more than $16.5 billion.

Prevention can have a major impact on these problems. Some of the behavior changes which can significantly improve health are, improved diets, eliminating tobacco use, using less alcohol, wearing seat belts and exercise. These behavior changes can be made at no additional cost to the individual or government. In fact, these changes lead to direct financial saving by the individual and substantial savings by society.

Many Americans are making these behavior changes. More Americans are exercising than ever before, the number of people who have quit smoking has doubled over the last twenty years, Americans are eating less fatty meat, and alcohol consumption is declining. Unfortunately, some segments of our society are not benefiting from these changes. Alcohol and tobacco use is more common among the economically disadvantaged then in the general population. Teenage pregnancy is a national epidemic and obesity has joined caloric deficiency as the major nutritional disease for those below the poverty line.

The Committee expects the Council to advise the President on national policy and federal programs that will support appropriate use of prevention services and will promote adoption of healthy behaviors in areas such as: 1) substance abuse including alcohol, drugs, and tobacco; 2) exercise, both risks and benefits; 3) nutrition including content and quantity of daily intake; 4) accident prevention; and 5) teenage pregnancies.

The Committee would like the Council to consider the effects health promotion and disease prevention can have on both the general population and various subgroups of the population grouped by age, sex, ethnic background, and economic status. The Council should also consider how to develop successful programs targeted at these various subgroups.

In completing this task, the Committee anticipates that the Council will look at some of the current recommendations and programs of the federal government in addition to state, local and private sector programs. The Council should highlight those recommendations and programs which it feels are effective and those which it feels are inappropriate or ineffective.

The Committee also anticipates that the Council will identify areas which are currently not being addressed, as well as areas where there is redundancy between federal programs or between federal and state programs.

The Committee anticipates that the Secretary of Health and Human Services will utilize the resources and staff of the Office of Disease Prevention and Health Promotion. This anticipation is reflected in the CBO cost estimate. The Committee feels that this is appropriate because of the overlap between the responsibilities of that office and the Council. The Committee expects that the Council's tasks can and should be integrated with on going policy development and monitoring roles carried out by the office as part of the latter's mandate to oversee health promotion objectives for the nation.

Historically, the federal government has taken a back seat in preventing disease. The federal government's health policy has been preoccupied with curing illness after it has developed. Although this has paid off handsomely, improving the quality of life of people everywhere, it is time to focus more attention on inexpensive and effective long term prevention efforts.

The Committee realizes that health promotion and disease prevention efforts are not a substitute for traditional programs aimed at providing nutritional support, housing, and medical care. Instead these efforts are aimed at supplementing existing efforts in these areas in an attempt to improve the health and well-being of all Americans.

VI. VOTES IN COMMITTEE

The motion to favorably report the bill to the Senate was passed unanimously by the Committee on Labor and Human Resources on March 19, 1986.

VII. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 25, 1986.

Hon. ORRIN G. HATCH,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 2057, the President's Council on Health Promotion and Disease Prevention Act of 1986, as ordered reported by the Senate Committee on Labor and Human Resources on March 24, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD GRAMLICH
(For Rudolph G. Penner).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2057.
2. Bill title: President's Council on Health Promotion and Disease Prevention Act of 1986.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on March 19, 1986.
4. Bill purpose: To establish the President's Council on Health Promotion and Disease Prevention.
5. Estimated cost to the Federal Government:

[by fiscal years, in thousands of dollars]

	1986	1987	1988	1989	1990
Estimated budget authority	100	350	50		
Estimated outlays	100	350	50		

The costs of this bill falls within function 550.

Basis of Estimate: This bill would authorize travel expenses and per diem allowances for Council members as well as salary and overhead for an executive director and staff. No specific authorization level is stated in the bill. Travel and per diem costs are estimated to be about $50,000 for the eighteen months life of the Council. We estimate the eighteen month cost of an executive director and two additional staff workers could be about $450,000. Costs could be higher or lower depending on the actual number of staff hired and on the frequency of Council meetings.

The Committee has stated that consideration should be given to appointing a director and detailing staff for the Council from the Office of Disease Prevention and Health Promotion within the Department of Health and Human Services. In this case, $450,000 for salary and overhead would be redirected in fiscal years 1986 and 1987 from the Office's current activities to the Council.

The estimate assumes an enactment date of June 1, 1986. The fiscal year distribution of estimated authorization levels would change given a different enactment date, but the total estimated cost of the bill over eighteen months would remain at $500,000.

6. Estimated cost to State and local government: The budgets of state and local governments would not be affected by enactment of this legislation.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: C. G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

VIII. ADMINISTRATION'S VIEWS

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, May 1, 1986.

Hon. ORRIN G. HATCH,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This is in response to your request for a report on S. 2057, a bill "To establish the President's Council on Health Promotion and Disease Prevention".

In summary, we are strongly committed to disease prevention and health promotion activities. We do not support the bill, however, as it would duplicate existing efforts and generate unnecessary costs.

The bill would establish a 15-member council, appointed by the President, whose purpose would be to: (1) advise the President on matters relating to building and maintaining maximal health for Americans; (2) advise the President about State and local disease prevention activities; (3) encourage State, local and private health promotion and disease prevention research and programs; (4) prepare an inventory of Federal, State, local and private programs and activities for health promotion and disease and injury prevention, particularly those aimed at subgroups who have special needs; (5) assess resources that are available, but not being effectively used, for health promotion and disease prevention and how those resources can be targeted to subgroups who are at risk; and (6) recommend to the President appropriate information dissemination methods and additional programs and activities for health promotion and disease prevention. The bill would require the Council to report to the President and the Congress within 18 months of the bill's enactment. The Council would then terminate.

Currently, we have an active Federal program to promote disease prevention and health promotion. The Department of Health and Human Services maintains an Office of Disease Prevention and Health Promotion within the Office of the Assistant Secretary for Health. The bill would duplicate many of the functions of this Office, whose purpose is to provide national leadership and Federal policy and program coordination. For example, the provisions in the new bill for compiling an inventory and conducting assessments of resources, with particular attention to high risk subgroups of the population, fall within the mission of the existing Office and could be done without new legislative authority. We have a very active effort involving experts in the field throughout the country and we coordinate our efforts with organizations and individuals at the State and local level.

The establishment of a President's Council would add increased costs to Federal administrative expenditures. In view of the government-wide efforts to reduce costs, it is not advisable to create a new Federal effort which would require additional appropriations or redirection of scarce resources from ongoing programmatic activities.

We therefore recommend that the bill not be favorably considered.

Departmental staff would be pleased to discuss our current program efforts with your staff and we would consider modifying our efforts to address any concerns you may have.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

OTIS R. BOWEN, M.D.,
Secretary.

IX. REGULATORY IMPACT STATEMENT

The Committee has determined that there will be minimal increase in regulatory burden or paperwork imposed by this bill. Furthermore, if the Council is able to identify areas where the government is ineffectively utilizing resources, there is the potential of reducing regulations and paperwork.

X. FAMILY FAIRNESS STATEMENT

The Committee feels that the legislation will have a positive impact on the family. The family is profoundly effected by preventable diseases and premature deaths, both financially and psychologically. When a teenager dies in an automobile accident from not wearing a seat belt or at the hand of a drunk driver; or when a teenager becomes pregnant; or when one of the family members is a substance abuser; or when any member of the family dies prematurely from a preventable disease, it effects the family. In short, the Committee feels that promoting health and preventing disease is a critical step towards promoting the family. The Committee also feels that the family should play a critical role in health promotion and disease prevention programs.

XI. SECTION-BY-SECTION ANALYSIS

The bill provides that the Act may be cited as the "President's Council on Health Promotion and Disease Prevention Act of 1986."

Section 2 of the bill amends title XVII of the Public Health Service Act to add a new section 1707, President's Council on Health Promotion and Disease Prevention.

The new section 1707(a) establishes the President's Council on Health Promotion and Disease Prevention.

Subsection (b) of the new section 1707 describes the duties of the new Council, which are to:

(1) Advise the President on matters concerning the building and maintaining of the maximal personal health of Americans;

(2) Advise the President on State, local, and private activities relating to health promotion and disease prevention;

(3) Encourage State and local governments and private entities in the development and conduct of research relating to, and programs and activities to foster, health promotion and disease prevention;

(4) Prepare an inventory of Federal, State, local, and private programs and activities for promotion of health and prevention of illness and injuries, particularly programs and activities directed toward subgroups of the population who have special risks to health;

(5) Assess which available health promotion and disease prevention resources are not being used by Americans and how such resources may be better targeted toward the subgroups with special risks to health; and

(6) Make recommendations to the President concerning:

(i) Appropriate methods to inform the public about available health promotion and disease prevention resources, including information on programs and activities in the inventory prepared by the Council; and

(ii) Additional health promotion and disease prevention programs and activities which should be undertaken to improve the personal health of Americans.

Subsection (c) of the new section 1707 describes the composition of the Council to be appointed by the President. Five members would be Federal, State, and local officers and employees with expertise and experience in health promotion or disease prevention. Four members would be representatives of academic institutions with expertise and experience in the field. Four would be representatives of public and private organizations with expertise and experience in the field. Two members would represent the general public.

Subsection (d) provides that members would be appointed for the life of the Council, with vacancies to be filled in the same manner as the original appointment.

Subsection (e) provides for the designation of a Chairperson.

Subsection (f) provides that the Council would meet at the call of the Chair.

Subsection (g) provides that eight members would constitute a quorum of the Council.

Subsection (h) provides that Council members would serve without compensation and be subject to provisions allowing travel expenses and per diem payments.

Subsection (j) provides for the Secretary to appoint and fix compensation for an Executive Director for the Council. The Executive Director would be an individual with expertise and experience in health promotion or disease prevention. Subsection (j) also provides for additional personnel and support services and facilities for the Council.

Subsection (k) provides for the Council to hold hearings, sit and act, take testimony, and receive evidence, as it considers appropriate. It also provides for the Council to secure necessary information from any U.S. department or agency to carry out its tasks. The Council may use the U.S. mails in the same manner and under the same conditions as other U.S. departments and agencies.

Subsection (l) provides that, within 18 months of the date of enactment of this legislation, the Council would prepare and submit to the President and the Congress a report describing its activities.

Subsection (m) provides that the Council would terminate at the earlier of: (1) 18 months after the date of enactment; or (2) 30 days after the President and the Congress receive the Council's report.

XII. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XVII—HEALTH INFORMATION AND HEALTH PROMOTION

GENERAL AUTHORITY

SECS. 1701–1706 * * *

PRESIDENT'S COUNCIL ON HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 1707. (a) There is established the President's Council on Health Promotion and Disease Prevention (hereafter in this section referred to as the 'Council').

(b) The Council shall—

(1) advise the President with respect to all matters concerning the building and maintaining of the maximal personal health of Americans;

(2) advise the President with respect to State, local, and private activities relating to health promotion and disease prevention;

(3) encourage State and local governments and private entities in the development and conduct of research relating to, and programs and activities to foster, health promotion and disease prevention;

(4) prepare an inventory of Federal, State, local, and private programs and activities for promotion of health and the prevention of illness and injury, particularly programs and activities directed toward subgroups of the American population who have special risks to health;

(5) assess which of the available health promotion and disease prevention resources are not being fully used by Americans and how such resources may be better targeted toward the subgroups described in paragraph (4); and

(6) make recommendations to the President concerning—

(A) appropriate methods to make available to the public information concerning available health promotion and disease prevention resources, including information concerning the programs and activities included in the intentory prepared under paragraph (4); and

(B) additional health promotion and disease prevention programs and activities which should be undertaken to improve the personal health of Americans.

(c) The Council shall be composed of fifteen members appointed by the President, of which—

(1) five shall be Federal, State, and local officers and employes who have expertise and experience in health promotion or disease prevention;

(2) four shall be representatives of academic institutions who have expertise and experience in health promotion or disease prevention;

(3) four shall be representatives of public and private organizations who have expertise and experience in health promotion or disease prevenion; and

(4) two shall be representatives of the general public.

(d) Members shall be appointed for the life of the Council. A vacancy in the Council shall be filled in the same manner as the original appointment was made.

(e) The President shall designate a member of the Council as Chairperson.

(f) The Council shall meet at the call of the Chairman.

(g) Eight members of the Council shall constitute a quorum, but a lesser number may hold hearings. A vacancy in the Council shall not affect its powers.

(h) Each member of the Council shall serve without compensation. While away from their homes or regular places of business in the performance of services for the Council, all members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under section 5702 of title 5, United States Code.

(j)(1) The Secretary shall appoint and fix the compensation of an Executive Director for the Council. The Executive Director shall be an individual who has expertise and experience in health promotion or disease prevention. The Secretary shall provide the Council with such additional personnel, and with such additional support serv-

ices and facilities, as the Secretary considers necessary to enable the Council to carry out its functions.

(2) Any Federal employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(k)(1) The Council may, for the purpose of carrying out this section, hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence, as the Council considers appropriate.

(2) The Council may secure directly from any department or agency of the United States information necessary to enable the Council to carry out this section. Upon request of the Chairman of the Council, the head of such department or agency shall furnish such information to the Council.

(3) The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(l) Within eighteen months after the date of enactment of this section, the Council shall prepare and transmit to the President and the Congress a report which describes the activities of the Council under this section.

(m) The Council shall terminate at the earlier of—

(1) eighteen months after the date of enactment of this section; or

(2) thirty days after the date on which the President and the Congress receive the report of the Council pursuant to subsection (l).

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